Leaving No One Behind

Feasibility Case Study: Applying the "Breaking the Silence" Approach in Comprehensive Sexuality Education for Adolescents and Young People with Disabilities during the COVID-19 epidemic

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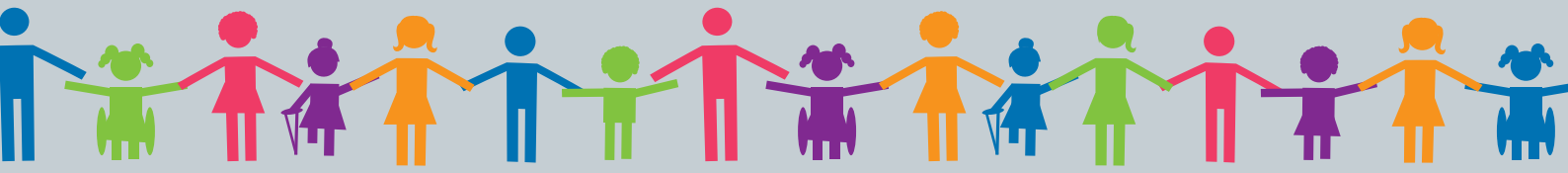

Participants in the Breaking the Silence Workshops

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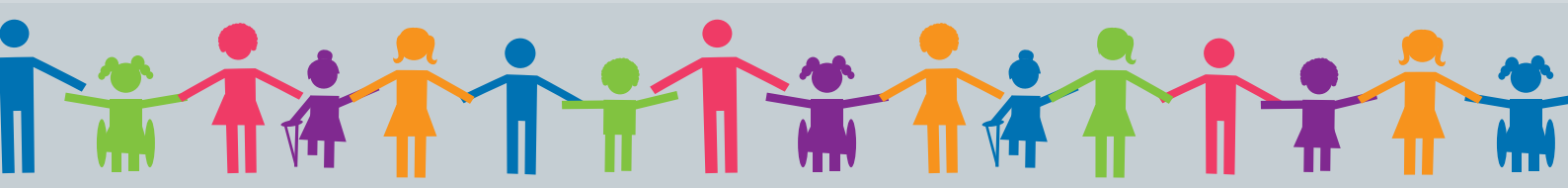

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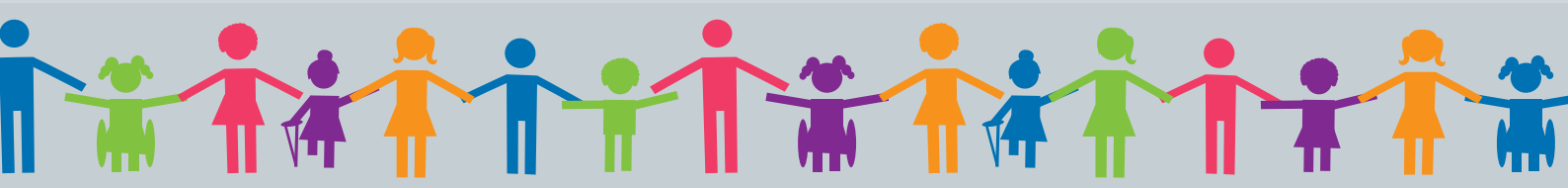
List of Abbreviations

BtS	Breaking the Silence
COVID	Coronavirus disease
CSE	Comprehensive Sexuality Education
CAPS	Curriculum and Assessment Policy Statement
CRPD	Convention on the Rights of Persons with Disabilities
DBE	Department of Basic Education
DPO	Disabled Peoples Organisation
ESA	Eastern and Southern Africa
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HoDs	Head of Departments
KII	Key-Informant Interview
NGO	Non-Governmental Organisation
L/O	Life Orientation
LS	Life Skills
PSH	Partners in Sexual Health
PWD	People with Disabilities
SAMRC	South African Medical Research Council
SDG's	Sustainable Development Goals
SGB	School Government Body
SPSS	Statical Package for the Social Sciences
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Right
STIs	Sexual Transmitted Infections
TPB	Theory of Planned Behaviour
TSEQ	Teacher Sexuality Education Questionnaire
UNFPA	United Nations Population Fund



Definitions

Reproductive health is defined by the International Conference on Population and Development (ICPD) Programme of Action as "a state of complete physical, mental and social well-being and 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 capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[3]

Sexual health is defined by the ICPD as "a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."[3]

Reproductive Rights, in turn, are seen by the ICPD as derived out of "established human rights protections; they are also essential to the realization of a wide range of fundamental rights. In particular, the following rights cannot be protected without ensuring that women and adolescents can determine when and whether to bear children, control their bodies and sexuality, access essential sexual and reproductive health information and services, and live lives free from violence".[3]

Sexual and Reproductive Health (SRH) Services as per ICPD include family planning, maternal health, preventing and treating sexually transmitted infections including HIV and AIDS, termination of pregnancy (TOR) and health information sharing. Sexual and Reproductive Health and Rights (SRHR) services include SRH services and services focusing on rights-based approaches, violence prevention and management, access to justice, and comprehensive sexuality education.[3]

Disability is an evolving concept. It results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis.[4]

Person with Disability – Persons with disabilities include those with long-term physical, mental, intellectual or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.[4]

The use of language and words describing people with disabilities has changed over time. People ought to be aware of the meaning behind the words they use when talking to, referring to, or working with the disability community. Disrespectful language can make people feel excluded and can be a barrier to full participation. Example of inappropriate and hurtful words used to refer to people with disabilities are 'the handicapped' or 'cripple'. The accepted and most used terms to refer to people with disabilities are:

Disabled people (disabled person): This term highlights that the "disabled person" is 'disabled' by his or her environment. Disability activists often use this term to emphasise the role of the environment.

People with disabilities: This term emphasises the need to see people as people first. The disability is just one characteristic that makes them who they are. The term also emphasises the group experience. For instance, many people with disabilities experience marginalisation and discrimination. Group experience and unification are emphasised by this term, which can be helpful in societies where communal life and experience is more important than individualism.

Persons with disabilities: The term 'person/persons' is used in legal documents. For instance, the Convention on the Rights of Persons with Disabilities (CRPD) uses the term "persons with disabilities". This term also emphasises the individual experience of disability and the need to see persons with disabilities as individual persons and not as part of a group.

Apart from this commonly used language when engaging with a person with disability we always have to recognise their choice of language, their diversity in terms of gender, age, race and other characteristics and how they want to be referred to. For instance, some people, who are deaf, prefer to be addressed as a group as 'the Deaf'.

Summary

Young people with disabilities have the same sexual and reproductive health needs and rights as their peers without disabilities. However, evidence in eastern and southern Africa shows that, compared to their peers, they are more vulnerable to HIV, unintended pregnancies, sexual violence and lack equal access to health care and information about their sexual and reproductive health rights (SRHR). Comprehensive Sexuality Education (CSE) is an important factor for young people with disabilities and enables them to claim their sexual and reproductive health and rights. Yet educators for these learners in and out of schools often lack the skills, confidence, methods, and resources to provide CSE in accessible formats. Additionally, negative perceptions linked to the sexuality of young people with disabilities drive a risk-protection approach, that favours abstinence and no sex messages instead of comprehensive information about the body, relationships, safer sexual practice, rights and rights protection.[5-9]

Leaving no One Behind and Breaking the Silence

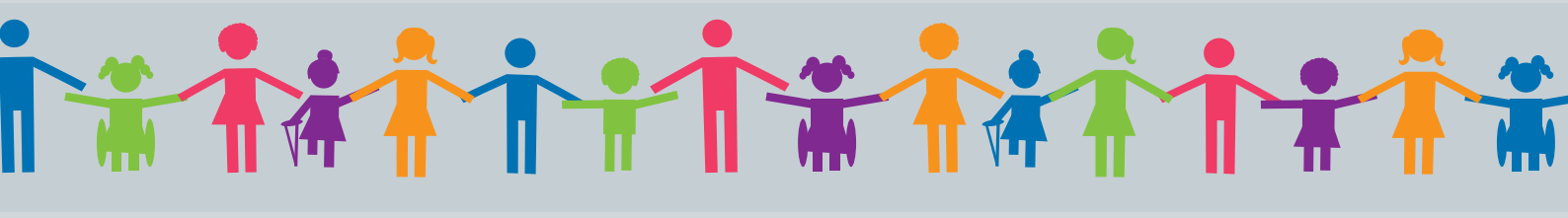
Breaking the Silence (BtS) aims to improve the SRHR in young people with disabilities through making CSE accessible to these young people both in and out of school. The Leaving no One Behind project utilized the BtS approaches (pillars: CSE, research, and policy) and supported the further testing and development of the BtS approach to CSE. The study presented here aimed to understand the feasibility, barriers and facilitators of implementing the BtS approach to CSE during the COVID-19 epidemic in two South African special schools. Educators and other school staff participated in a three-day training workshop to build educators' self-efficacy to implement CSE with learners with disabilities. The training is supported by the BtS Comprehensive Guide and 15 Lesson plans to equip educators with knowledge, visual resources (translation for Braille or verbal instructions) and practical activities for classroom use and beyond (e.g. parents, peer education). The approach is ideally implemented as a whole school intervention supported by the school management.

Two schools were allocated by the DoE, school A for learners with intellectual disabilities and school B for learners with hearing impairments and the Deaf. The three-day BtS training was delivered on site in each school adhering to COVID regulations (sanitising, social distancing and wearing of face masks). Before the training, we assessed the school environment and educators' knowledge, self-efficacy, subjective norms, teaching beliefs and practices regarding CSE through consultations with school management and HoD's as well as a baseline questionnaire (TSE-Q). Fifty participants completed the baseline study and twenty-six participated in the training programme. Interviews revealed that some educators could not participate on the training dates as they needed to be teaching (COVID regulations had rescheduled the workshops into school terms) or were simply against CSE and therefore chose not to participate. Directly after the training, we re-assessed the knowledge, attitudes, and beliefs of the participants who attended through a short-written evaluation, repeating the TSE-Q and key informant interviews with nine educators. With these tools, we investigated educators' attitudes and practices toward CSE, the barriers and facilitators they identified for the implementation of CSE with the BtS approach as well as their perceptions of implementing BtS during the COVID-19 pandemic.

Situational analysis prior to the Breaking the Silence workshops

Educators adapted and drew on the curriculum available from DoE but lacked any DoE training or adapted materials to meet their learners needs. In school A, two educators had been trained (in the previous pilot BtS workshop), but experienced little engagement from other staff members. In this school, (for learners with intellectual disabilities), sexuality education began in the senior phase. In school B, (for learners with hearing impairment and the Deaf), CSE was provided by an external community-based organization for the Deaf on dedicated school camps, but no written curriculum or materials could be provided. At this school, educators taught CSE topics on an adhoc basis in relation to their learner needs, often in response to a crisis (i.e. observing sexual activity at school). Neither school had internal guidelines, monitoring or evaluation of sexuality education and educators implemented of their own accord. Sexuality education lessons in both schools were guided by a risk and abstinence focus, encouraging learners not to engage in sexual activity but providing little information about human body development, sexual health, and behaviour. However, many educators indicated agreement to teach CSE topics on the TSE-Q teaching belief scales. A comparison between teaching beliefs and teaching practice/behaviour in different CSE topics revealed that although educators believed they should talk about many of the prompted CSE topics, they were not implementing them. The greatest difference was noted in the area of sexual behaviour and sexual health showing that educators rarely approached these topics.

In school A, educators were ambivalent about receiving CSE training but educators in school B were receptive



and recognised the importance of CSE for their learners. However, the base line study showed educators from both schools held misperceptions that CSE sexualises children. These misperceptions are fueled by anti-CSE propaganda on social media. In school B educators were sensitive to their learners increased vulnerability to sexual abuse but felt unqualified and unsupported when responding to these cases. In contrast, educators in school A were initially hesitant to talk about the abuse of their learners with disabilities. However, after continued engagement with the school, participants related their learners' vulnerability to sexual abuse, gender-based violence and unintended pregnancy. The experience of stress and corresponding lack of support in relation to reporting sexual abuse was a dominant theme during both training workshops.

Feasibility Study post Breaking the Silence workshops

Negative attitudes toward CSE and the sexuality of learners with disabilities is a major barrier to implementation and the inclusion of the range of learning topics necessary to effective CSE. The prevalence of anti-CSE propaganda, experienced by some educators, reinforces this barrier, alongside ambivalence and resistance. However, the BtS training facilitated a shift in educator's attitudes toward being supportive of CSE. Post training, fewer educators believed that CSE sexualizes children and more agreed that CSE increases learners' self-confidence and the ability to report violence as well as increasing learners' tolerance toward different sexual orientations and gender identities. In the post workshop interviews participants emphasized the change in their beliefs about CSE and the power of the BtS approach to enable them to speak about topics related to the body, relationships and sexuality. This view was reflected in the post workshop survey by increased agreement that their CSE lessons should include information on sexual development, sexual behaviour and sexual health as well as sexual identity and orientation. Discussions and information provided in the workshop on disability and sexuality also resulted in fewer misconceptions about the sexuality of learners with disabilities. For example, more educators disagreed that learners cannot engage in sexual activity, are hypersexual or oversexed. Although the post-workshop survey showed that many teaching beliefs improved, for some areas, there was little change (positive or negative) as the believes were already relatively high at baseline. Although there were improved beliefs around the need to teach about sexual health, more educators believed that they do not need to teach about contraceptives, which indicates that this item needs to be strengthened in the BtS workshops.

In the post-workshop interviews, participants commented that their learners were already exposed to sexual information and that some were sexually active or exposed to abuse and therefore in need of accurate information about sexuality as well as the skills to be able to prevent or report sexual abuse. This was corroborated by the post workshop survey by more educators agreeing they should teach about values, decision-making, communication, assertiveness, negotiation skills, and looking for help. Understanding the reality and vulnerability of learners with disabilities was seen as an enabler of CSE and many participants emphasised the need for school management to be exposed to the training in the need to support implementation. The support of principals or organisational leaders, and a whole school/organisation approach, was regarded as an important enabler of CSE in the post evaluation feedback as well as the key informant interviews. Educators, who did not attend the workshop were seen as a potential barrier if they held negative cultural beliefs about CSE. This was evidenced by the two educators from school A who had been trained previously but despite being given permission to implement CSE remained isolated in their school context prior to the BtS workshop in 2021.

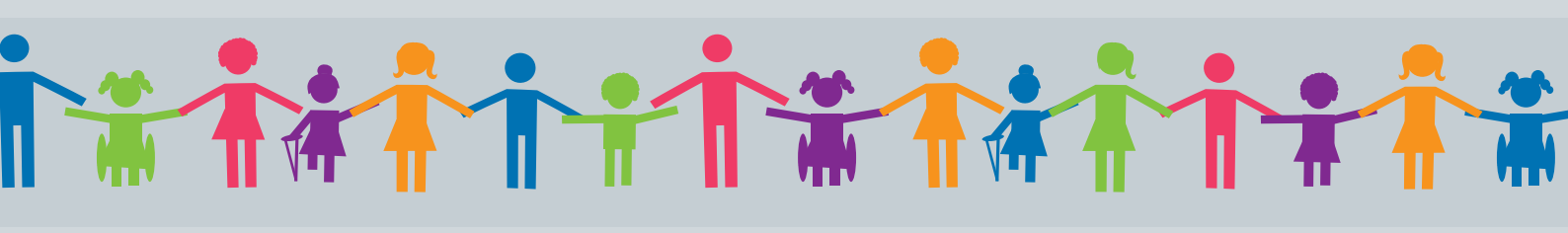
Another enabler to implementation of CSE was the ability to adjust teaching material to the learners' needs, build vocabulary and demonstrate concrete concepts using a variety of sensory channels. This view was echoed in the post workshop evaluation where educators viewed BtS participatory teaching tools, such as games, pictures and stories as enabling implementation in a way that was accessible as well as fun and practical. Educators linked this participatory style of teaching with a rights-based approach where learners make more informed decisions and make their needs known. The BtS approach of using signs, symbols, pictures (translations for Braille or verbal instructions) to support key learning concepts strengthens the learning process and is essential for learners with intellectual disabilities. Educators from school B reinforced the efficacy of this approach with learners with hearing impairments or the Deaf. Hence, BtS showcased how universal design to teaching can be implemented meeting the needs for a variety of different disabilities, while providing specific adaptations (reasonable accommodation), where universal design is not enough.

In the key informant interviews and post-workshop short evaluations participants emphasized the involvement and education of parents as being an enabler of CSE and suggested that parent meetings are therefore crucial. These meetings were needed to educate parents on how knowledge about the body and rights can be empowering and protective of their children rather than promoting sexual behaviour. Participants also indicated that house mothers had a similar role to play to support implementation, as many learners with disabilities attend 'special school', which are far away from their homes and therefore have boarding establishments.

In the post-workshop interviews participants explained that the COVID-19 lock-down in 2020 had a significant impact on the structuring of lessons, specifically lesson time. Shorter lesson times meant that completing the curriculum has become challenging and this has come at the expense of CSE. Participants emphasized that learners with disabilities however require intensive and flexible learning time. The tendency of taking a risk focused approach to CSE is further exacerbated by adapted 2020 Content Phase Plans for Grade 4-6 and 7-9 due to COVID regulations which further restrict CSE related content to a mainly disease (COVID and HIV) and abuse prevention focus. However, some participants saw the social distancing regulations of COVID as an opportunity to explore closeness, relationships, physical touch, and even sexual activity. Educators also observed how COVID-19 lockdown increased their learner's vulnerability and experience of sexual abuse. This observation links to the corresponding stress expressed in the training concerning educator's duty to report and support learners in a system they experienced as unresponsive and inadequate to the increased support needs of their learners with disabilities.

Discussion and recommendations

This study aimed to understand the feasibility, barriers and facilitators of implementing the BtS approach to CSE during the COVID-19 epidemic in two South African special schools. The study reinforces the need to provide training and support for educators to provide CSE to learners with disabilities. It also shows that despite anti-CSE propaganda fueling educator fears and misperceptions of CSE, it is possible to facilitate a change in beliefs to become supportive of CSE as integral to empowering learners with disabilities and that most importantly, this is possible in a relatively short period of time. Key enablers in the intention to deliver CSE includes; understanding learners needs and their vulnerability, increasing the capability to adjust teaching material and interactive methods (alongside providing adapted teaching materials and resources) and effecting a whole school approach to enable an integrated approach to improving learners SRHR through accessible CSE.



Introduction

Background to the Study

Leaving no one behind has become an international proverb to express our vision to include everyone through addressing barriers to participation and provide access to all spheres of life. This is of particular importance for marginalised populations such as young people with disabilities and sensitive topics such as sexual and reproductive health and rights.

Adolescents and young people with disabilities have the same sexual and reproductive health needs and rights as their peers without disabilities. However, evidence in eastern and southern Africa (ESA) shows that they are likely to experience worse sexual and reproductive health (SRH) outcomes than their peers.[2] Including infection with HIV/STIs, unintended pregnancies, higher risk of rights violations (including exposure to violence), and lack of equal access to health care and information about their sexual and reproductive health and rights (SRHR). [10-14]

Literature on SRHR and people with disabilities in ESA is still scarce because mainstream SRH(R) research seldom includes disability indicators, and disability-specific research is rarely funded and supported.[15] The most detailed data is available from the field of HIV and gender-based violence (GBV) before the COVID-19 epidemic.[2,16,17] This emerging evidence revealed that people with disabilities are at least at the same risk of HIV infections as their peers without disabilities, yet lack access to SRHR/HIV and related services.[18-21] Further investigation revealed that the risk of HIV infection is higher among women with disabilities than people without disabilities.[19] This increased risk is driven by transactional sex and sexual violence.[19] Similarly, the What Works programme found that in low- and middle-income countries (LMIC, including ESA), women with disabilities are two times more likely to experience intimate partner violence (IPV) than their peers without disabilities and that this risk increases with the severity of disability.[22-24]

Furthermore, studies revealed that the increased risk of adverse SRHR outcomes such as HIV, GBV, and IPV among people with disabilities are linked to misconceptions about their sexuality and discrimination based on disability and gender; lack of knowledge among people with disabilities about sexuality, rights, and HIV; lack of skills among staff in health, education, and law enforcement services to serve people with disabilities; lack of accessible service facilities and programmes; and the high economic dependency and poverty among people with disabilities and their families.[2,11,17,23,25,26]

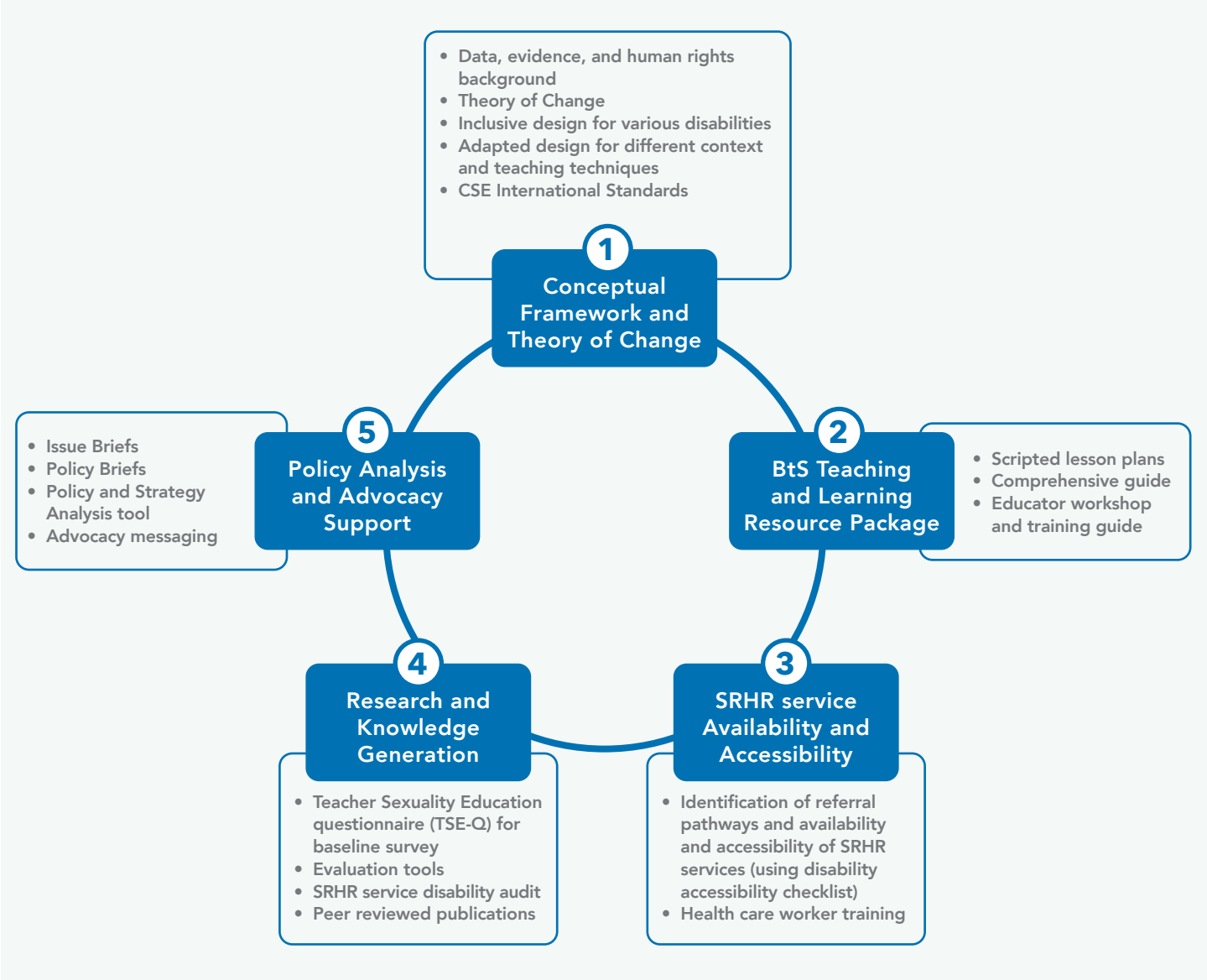
For adolescents and young people with disabilities in South Africa, the risk of adverse SRHR outcomes is particularly exacerbated. Firstly, households with children, adolescents and young people with disabilities are among the poorest households in the country.[27-29] These households have lower earnings levels and higher levels of opportunity costs and disability-related expenses than households without people/children with disabilities (DSD). Secondly, children and adolescents with disabilities are more likely to be out of school. The DSD report on the Elements on the Financial and Economic Costs of Disability in South Africa revealed that 30% of out of school children have a disability (while only 8% of children in South Africa are children with disabilities).[27] Research on sexuality education shows that even if children with disabilities go to school, they do not have access to or are even actively excluded from sexuality education.[6,7,30-35] This level of disparity and exclusion has dire consequences.

The South African National HIV Prevalence, Incidence, Behaviour and Communication Survey showed that the prevalence of HIV is higher among young people with disabilities than their peers without disabilities (HSRC, 2009).[36] Small scale studies revealed that learners with disabilities lack knowledge about HIV and sexuality[5,6,37-41]. Chappell's qualitative work with youth with disabilities revealed that young people with disabilities have limited access to information about HIV and sexuality (as available information is not in an accessible format), but that the taboo surrounding sexuality leads to young people with disabilities developing a 'secret language and code" to gain information about the topic.[37-39]

This 'secret language' included misinformation about HIV and sexuality. Furthermore, work from Rohleder and Hanass-Hancock revealed that sexuality education is often not available at schools that cater for learners with disabilities as educators in these schools often lack the skills and confidence to teach sexuality education, lack tools and methods to provide sexuality education in accessible formats and are driven by a risk-protection approach, that favours abstinence and denial of normative youthful sexuality instead of comprehensive information about the body, relationships, safer sexual practices, rights and rights protection.[5-9]

Lastly, even when young people have access to correct information about HIV and sexuality, they still experience environmental, communication, and attitudinal barriers

Figure 1 Overview BtS approach 5 Pillars



at the healthcare service provider level.[2,16] These barriers include negative attitudes, a lack of accessibility measures, and insufficient staff trained to support people with disabilities. In response to this gap, the Breaking the Silence (BtS) approach was developed. BtS includes five pillars focusing on developing a theory of change, increasing educators' skills to provide CSE, increasing knowledge about the accessibility of healthcare services, appraising and developing inclusive SRHR policies, and increasing knowledge generation and translation about SRHR and disability (see figure 1).

Sexual and Reproductive Health and Rights and Young People with Disabilities

Sexual and reproductive health and rights (SRHR) are essential for young people in all their diversities to achieve their human rights and potential in life. However, in many countries in ESA, young people's sexuality and sexual activity are seen as taboo topics rather than spoken about, prevented, or even forbidden.[2,16] As a result, young people experience several barriers to access correct and timely information about their sexual development and sexuality.[2,16] They also often lack access to adequate SRH and SRHR services without prejudice. [2,16]

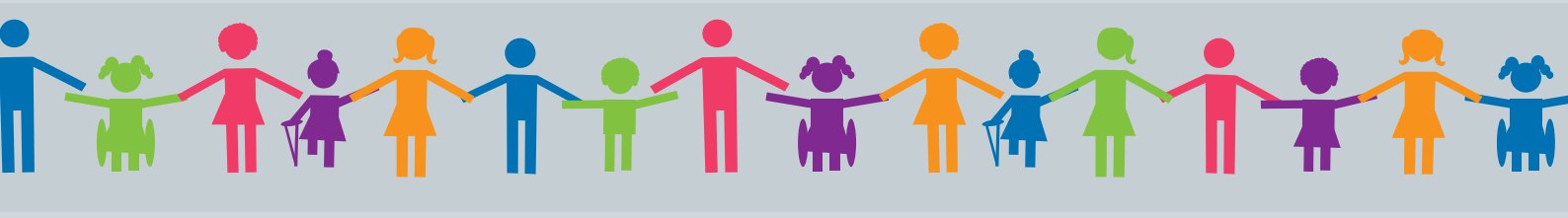


Figure 2 UNFPA Intersection of SRHR, gender and disability[2]

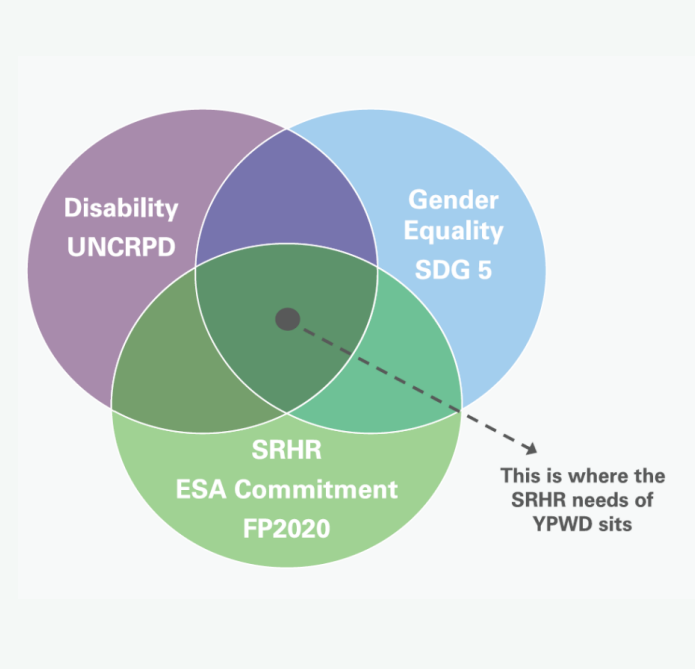
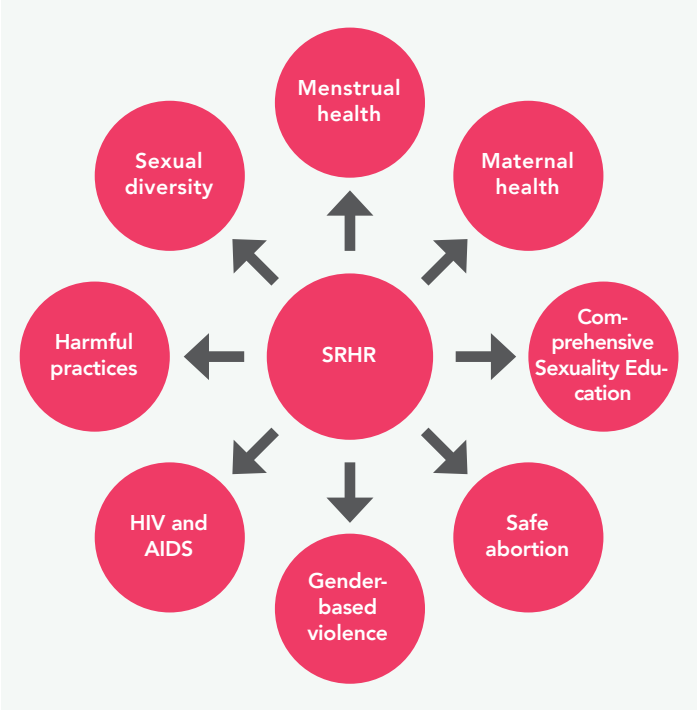


Figure 3 Overview of SRHR Services (Gender Links)



These barriers are not only related to age but are also exacerbated due to disability, gender, and sexual orientation.[2] The intersection (figure 2) of these factors leads young people with disabilities to experience multiple barriers that deny them the ability to lead a healthy, safe, and empowered life.

Important regional and national guiding documents and commitments already promote the SRHR of young people with disabilities.[2] The Convention on the Rights of Persons with Disabilities (CRPD) protects the rights of people with disabilities to health, including SRH (Article 25), freedom from violence (Article 16), accessibility of services, facilities and communities (Article 9), and family rights (Article 23)[4]. The Sustainable Development Goals (SDGs) promote the right to health for all, gender equality and elimination of discrimination against women and girls (SDG 3 and 5).[42] Furthermore, the Ministerial Commitments on SRHR aim to improve access to SRHR for young people in ESA.[43]

However, the inclusion of people with disabilities does not yet adequately reflect in ESA countries' SRHR policies and strategic plans.[2,44] It is mostly forgotten or an afterthought in implementing SRHR services in the region.[2] Our recent report on South Africa SRHR policies and strategic plans shows that commitments are much better integrated on paper while implementation guidelines and approaches are lacking.[45] The Breaking the Silence intervention is one such approach, and this study focuses on testing it's feasibility (https://www.samrc.ac.za/intramural-research-units/breaking-silence).

SRHR services cover several areas, including menstrual health; maternal health; Comprehensive Sexuality Education (CSE); safe termination of pregnancy (abortions); family planning and access to contraceptives; programmes addressing gender-based violence, harmful practices, and HIV and AIDS; and support for sexual diversity (figure 3).[2,46]

Research with young people in ESA showed their heightened vulnerability[43]. It inspired innovative approaches such as youth-friendly SRH services, CSE in mainstream schools, and medical innovations such as HIV self-tests and pre-exposure prophylaxis.[47,48] However, these innovations have not reached young people with disabilities equally and are inaccessible for some learners[2,13,49'50] In addition, the recent COVID epidemic has increased these inequalities. The 'Global Report on COVID-19 and disability' revealed the severe breakdown of support for persons with disabilities, who were without access to necessities such as food and nutrition, lacked information on how to keep themselves safe, were forced to battle against significant barriers to receiving healthcare, even for those with long-term and chronic health conditions.[51] However, the SRHR of young people with disabilities is silent even in this report. We do not know whether young people access SRHR services under COVID-19 and whether this includes Comprehensive Sexuality Education.

Sexuality Education and Learners with Disabilities

Comprehensive sexuality education is a cornerstone of providing SRHR services and essential to filling the region's service gap. The UN Technical Guidelines on CSE state that *"Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to: realize their health, well-being, and dignity; develop respectful social and sexual relationships; consider how their choices affect their well-being and that of others; and understand and ensure the protection of their rights throughout their lives".*[1]

The guidelines lay out eight key concepts that need to be covered in CSE (figure 4). While many ESA countries, including South Africa, have accepted CSE, it is still a controversial subject to some. Intensive educator training is needed to improve the knowledge, attitudes, confidence and skills amongst educators and increase the availability of adequate resources for this subject.[1] CSE also needs to respond to the specific vulnerabilities and learning needs of learners with different types of disabilities.

Figure 4 Eight key concepts of CSE in UN Technical Guidelines on CSE[1]

However, the scarce research available on CSE and disability in ESA reveals that learners with disabilities lack access to CSE even if they are at school and have insufficient knowledge about sexuality and keeping themselves safe from STIs, such as HIV[2],[5,6,38,39,41,52-55]. In addition, educators of young people with disabilities have been reported to hold negative attitudes towards CSE. They also reportedly lack confidence and skills to teach CSE in accessible formats to their learners.[7,31,32,35] Community norms and values or educators' perceptions of how communities and parents might react to CSE provide additional barriers to CSE implementation in mainstream and special schools[7]

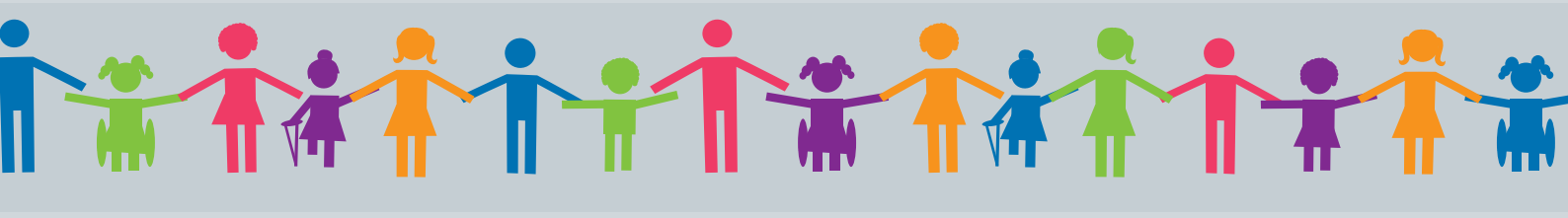
One of the innovations to increase access to SRHR information among young people with disabilities is the Breaking the Silence (BtS) approach to CSE.[8] The approach focuses on enabling educators to provide accessible CSE through working through their norms and values, increasing confidence and skills to provide CSE and structuring a supportive environment for CSE. At the beginning of this project, the first pilot studies of the BtS CSE approach indicated that the approach enabled educators to implement CSE.[8] However, it needed to be further tested as a whole school approach.40 Unfortunately, at this stage in the development of BtS, the COVID pandemic began to spread throughout the world.

During the first waves of the COVID pandemic, many schools were closed in ESA. As a result, learners lost crucial teaching time in 2020 despite efforts to make online schooling available. How this loss in teaching and learning and additional COVID regulations impacted the implementation of CSE and how it specifically affected implementation in schools that cater for learners with disabilities was at the onset of this project unknown.

Leaving No One Behind and Breaking the Silence

Within the pledge to leave no one behind is the commitment to examining why people are left behind, to empower those left behind and then enact interventions to confront barriers that leave people behind.[56] The Leaving No One Behind project from Partners in Sexual Health addresses the sexual and reproductive health (SRH) and rights (SRHR) of young people with disabilities by providing comprehensive sexuality education (CSE); and increasing access to SRHR-related interventions in South Africa[57]. Leaving No One Behind focused on understanding the barriers to SRHR health and educational services for young people with disabilities and identifying a good practise to close the gap. Embedded within the Schools Out campaign, the project seeks to advocate for the SRHR of young people with disabilities. In collaboration with the South African Medical Research Council (SAMRC) and United Nations Population Fund (UNFPA) with support from the Department of Basic Education (DBE) Leaving No One Behind supported the feasibility study of the "Breaking the Silence" approach to CSE.

Accessible and adequate CSE is key to changing the status quo and empowering young people with disabilities to claim their SRHR. However, in order to provide adequate CSE in accessible formats, the legal framework needs



to support CSE and access to SRHR for this group, government and school leadership has to support the implementation, funding needs to be available, and the workforce (educators) needs to have the skills to implement CSE. In addition, we need data that shows us if our approaches work, tools and resources (products) that teachers can use in the classroom, and service delivery models that are feasible.[2]

The research component of the Leaving No One Behind project addresses the last three needs. It focused specifically on the BtS approach CSE pillar, the testing of the BtS workshop, educator training, and implementation of the approach under COVID-19 regulations.

The Breaking the Silence approach CSE pillar is an evidence-based 'curriculum-implementation approach'[58] that focuses on providing CSE that is accessible to learners with disabilities. It draws on social learning theory and offers a structure for group-based learning, participatory methods and a whole school approach including community, parent and peer support.

In order to 'Break the Silence' surrounding disability and sexuality, the approach aims to:

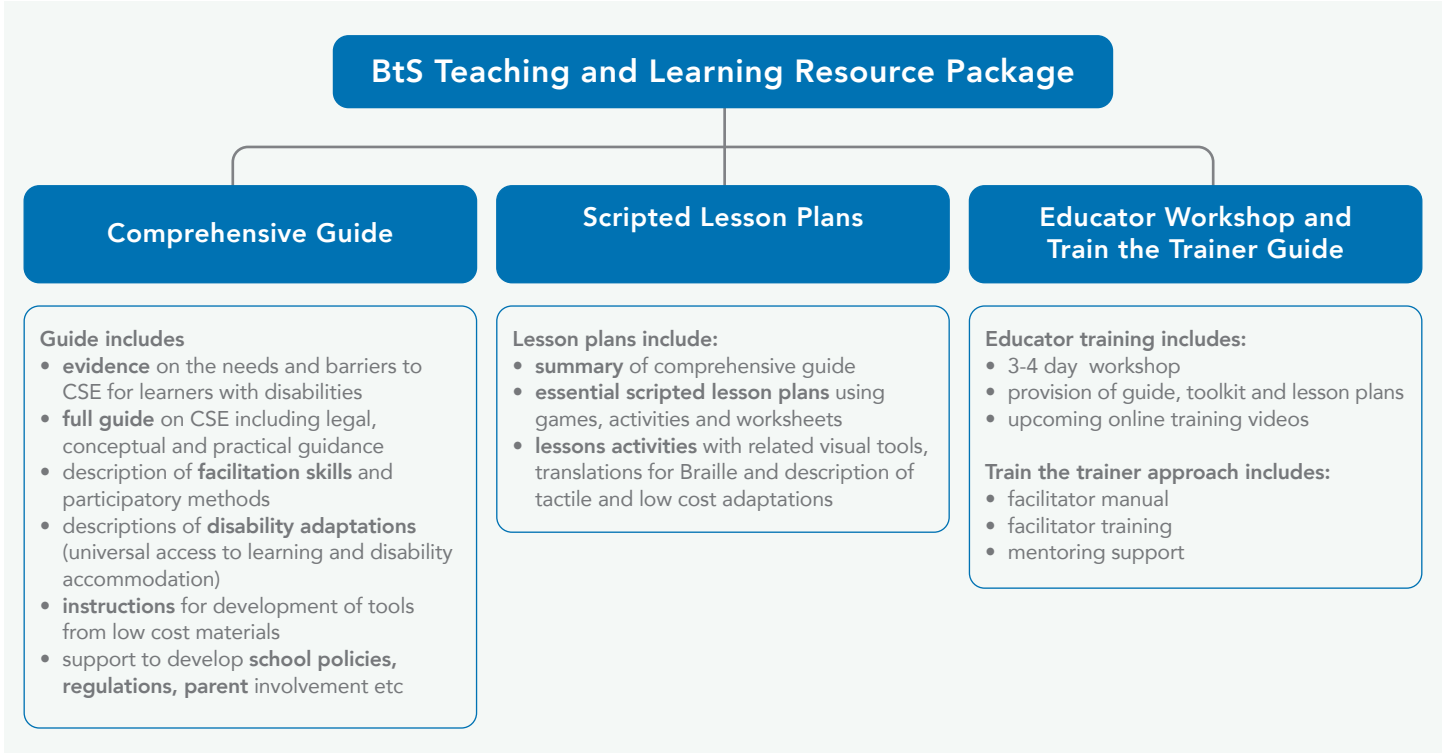
a) provide educators with the skills, approaches and tools to deliver comprehensive sexuality education in the classroom, and
b) stimulate normative changes to overcome personal and community-driven social and cultural barriers[7,9,59]
c) apply the principles of universal design and reasonable accommodation to the teaching approach.

The approach is ideally implemented as a whole school intervention supported by the school management. It integrates several supportive programmes (such as educator training and support, parent support groups, and peer education).

The central element of this approach is a group-based, three- to four-day training programme that aims to advance educators' perspectives (attitudes), internalised norms, facilitation skills and self-efficacy, and provide them with a toolkit that equips them with knowledge, visual resources (translation for Braille or verbal instructions) and practical activities for classroom use and beyond (e.g. parents, peer education). For this purpose, the BtS team has developed a Comprehensive Resource Guide, 15 essential lesson plans and an educator workshop training guide (figure 5).

Leaving No One Behind utilized the BtS approaches (pillars: CSE, research, and policy) and supported the further testing and development of the BtS approach to CSE. In order to test the practicability of implementing the BtS CSE pillar, the project included a feasibility study. This study aimed to understand the feasibility (practicability of implementing

Figure 5 Breaking the Silence approach to CSE



the training and identifying barriers and facilitators) of implementing the BtS approach to CSE during the COVID-19 pandemic in two South African special schools. The study addresses the following sub-objectives:

Objective 1:

- To describe the two different settings, including the schools and community backgrounds, and to inform the schools CSE guideline development (a situational analysis of school environment and preparedness to implement CSE)

Objective 2(a&b):

- To assess educators' attitudes, skills, levels of confidence, and teaching practices, and how they relate to implementing CSE before exposure to BtS, how attitudes, skills and confidence may change after exposure to BtS and

- To describe educators' perceptions on how COVID-19 might impact the implementation of CSE and the BtS methods (educators' attitudes, skills, perceived norms and confidence)

Objective 3:

- To describe barriers and facilitators of implementing BtS as a whole school approach under the current COVID-19 epidemic and in future from the perspective of educators, managers, school health care staff, house mothers or parent representatives (perception of feasibility)

Objective 4:

- To reassess the face and content validity of the BtS research tools (school situational analysis question guide, TSE-Q) while performing a situation analysis of the whole school and identifying areas that needed to be addressed to enable implementation of CSE

Methodology

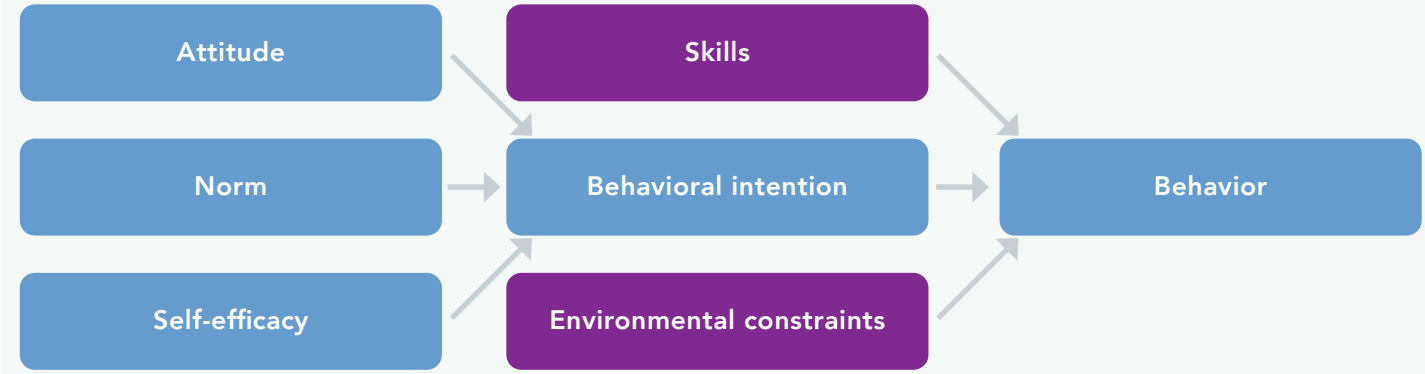
Feasibility Study Design

The feasibility study included two case studies at two different special schools in South Africa using the BtS research methods (BtS research pillar). The study used a mixed-methods approach and the adapted theory of planned behaviour (TPB) to develop the study tools (questionnaire/survey and question guide).[43] The TPB also guided the development of the BtS tools and theory of change (Appendix 1).[9,44,45]

The TPB theory postulates that individual behaviour (e.g. teaching behaviour) is determined by a person's intention to perform that behaviour, which in turn is determined by a person's knowledge and attitudes, self-efficacy, and perceived subjective norms. Also, in the adapted TPB, skills and the contextual environment are essential factors that influence behaviour (see figure 6). Hence, for educators to implement CSE, they need to have the intention to implement CSE and the skills and environmental conditions. The BtS approach to CSE works on all three components through a workshop training that focuses on norms, attitudes, self-efficacy (building intention), and skills development of educators. Educators also receive a comprehensive guide, 15 lesson plans and visual resources to implement BtS after the workshops[60,61]. In addition, the BtS approach to CSE includes a school situational analysis, development of school CSE guidelines and a whole school approach to ensure that the environment is supportive of implementing CSE.

In collaboration with the Department of Education, two special schools allocated by the DoE, one in eThekweni and one in Cape Town, were selected for the case studies. Educators and other school staff were exposed to a three-day training with the BtS approach to CSE that addressed knowledge, attitudes, beliefs, skills, and environmental barriers and builds self-efficacy to implement CSE with learners with disabilities. Before the training, we assessed the school environment and educators' knowledge, self-efficacy, subjective norms, and teaching beliefs and practices regarding CSE. Because of COVID-19 lock-down regulations, the face-to-face training had to be delayed for several months. Directly after the training, we re-assessed the knowledge, attitudes, and beliefs of the trained educators. We also assessed educators' and school members' perceptions of implementing BtS during the COVID-19 pandemic. With these tools, we established educators' intention to implement different elements of CSE and what barriers and facilitators they identified for the implementation of CSE with the BtS approach (feasibility).

Figure 6: Adapted version of the Theory of Planned Behaviour. Adjusted from US department of Health and Human Service [43,46]



Sampling and Recruitment

Sampling: Participants for this study were recruited from two pre-identified schools. The schools were identified by the DoE and included one school for learners with hearing impairments and the Deaf and one school for learners with intellectual disabilities. Objective 1 was conducted with the school management and CSE educators.

For objective two, we offered participation to all members of the participating schools (Convenient sampling). Although 50 potential staff and community members participated in our baseline survey and were offered the BtS course, only 26 staff and community members opted to be trained with the BtS approach to CSE (convenient sampling).

We used maximum variation sampling for objective three, covering educators from different grades, school health care staff, NGO representatives, and house mothers/parents. We sampled participants until we reached saturation but didn't get an interview with school management as they could not participate in the workshops (purposely sampling, see table 1).

Table 1 Sampling

	School A, TSE-Q survey N pre- and (post)	School B, TSE-Q survey N pre- and (post)	School A Key-Informant Interviews	School B KII Key-Informant Interviews
School management	0 (0)	2 (0)	0	0
Teachers	16 (9)	9 (4)	3	1
NGO representatives working with school on SRHR or CSE	n/a	6 (6)		1
Health care staff Psychologist or nurse or occupational therapist	3 (3)	2 (2)	2	1
Housemothers or parent representative/ caretakers	12 (2)	0 (0)	1	0
Total	**31 (14)**	**19 (12)**	**6**	**3**

Recruitment procedure: Schools were recruited through engagement with DoE, which supported the training of educators with the BtS approach. In collaboration with the school, we identified educators and support staff to participate in the BtS workshops. For objective 1, we approached school managers and heads of departments (HoDs) concerned with sexuality education. Participants were then recruited from the participating schools and their collaborating NGOs and identified with the school management as part of objective 2. Lastly, in objective 3, we purposely selected members from each school for key-informant interviews using the pool of participants who had undergone the BtS training (maximum variation sampling: educator, nurse/psychologist, house mother/ parent and community representative).

Research Tools

Objective 1 (O1)

In order to describe the school and community setting, we conducted a series of consultations with the school management and HoDs overseeing Life Orientation, including sexuality education. In these consultations, we assessed the school environment and its preparedness to implement CSE. These consultations discussed the availability of school CSE guidelines, educator training on CSE, CSE resources and teaching tools, and established referral networks for SRHR issues (table 2, School situation analysis question guide).

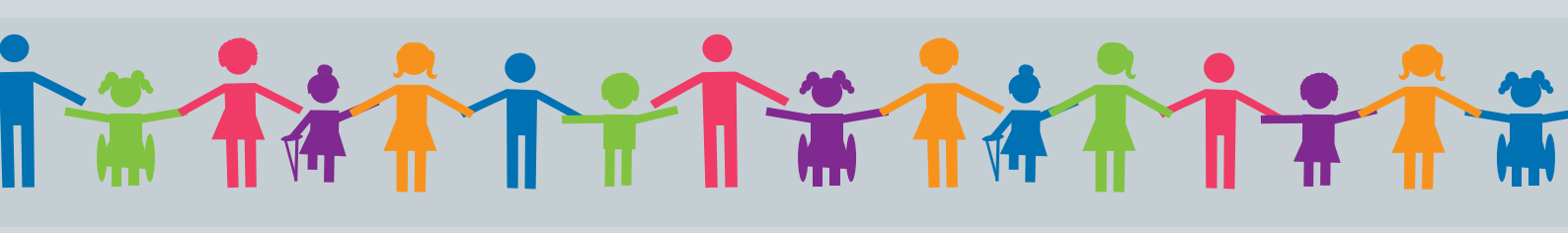


Table 2 School Situation Analysis

Item prompted	Response	Documents viewed
School and Community Environment		
1. What documents does the school use to guide CSE? 2. Has the school developed CSE guidelines (which one's)? 3. How are parents and caregivers (house mothers) informed or involved in the provision of sexuality education? 4. What is the parent/caregiver's and community member's response to the provision of sexuality education? 5. How (and where) does the school refer learners who need SRHR services? 6. What socio-cultural barriers and enablers does the school experience in implementing CSE (educators, parents, or community members)?		
CSE Leadership and Guidance		
7. Who is responsible for making sure CSE is delivered, overall and in each phase? 8. Who is responsible for ensuring the CSE curriculum is delivered to learners, and how is this achieved? 9. How is CSE implementation monitored?		
School Curriculum		
10. Is sexuality education part of the curriculum (subjects)? 11. Is the CSE curriculum written down? Or Which subjects have a written curriculum for your educators? 12. What learning topics are part of this CSE curriculum? 13. How are the learning topics delivered across the learning phases?		
Educator Training and Support		
14. What type of CSE training have educators received (content, timeframes and year)? 15. Who has received CSE training? 16. Do educators follow a CSE written curriculum? 17. Which CSE topics do educators already implement and in which subjects or forms? 18. What are the core issues that educators are responding to concerning sexuality and learners? 19. What is the approach to supporting educators to implement the CSE curriculum?		
Available tools and resources		
20. What resources are used to teach CSE in the school? 21. What resources are still needed to teach CSE in this school? 22. What further support does the school need to respond to arising issues?		

This data was collected during the project and entered into a mapping tool designed for this project. The data provided us with an overview of the schools' preparedness to implement CSE and what potential structural barriers and facilitators each school is experiencing. This assessment informed the development of the school CSE guidelines.

Objective 2 (O2)

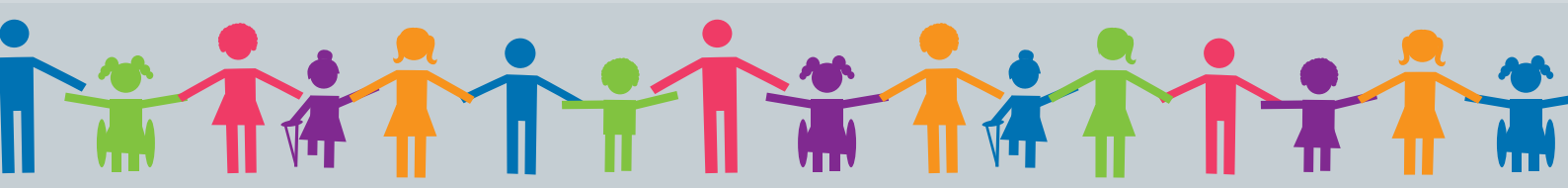
In order to assess educator attitudes, perceived norms, skills, confidence and how they relate to implementing CSE (reported teaching practice), we conducted a baseline survey with an adapted version of the BtS Teacher Sexuality Education Questionnaire (TSE-Q).[45] The original TSE-Q questionnaire was developed, piloted, and validated in KZN and included self-developed and culturally adapted scales from Howard-Barr and Mathews (see table 3).[44,45,47,48] For this study, we adapted the questionnaire and included self-developed questions prompting the teachers' knowledge and beliefs about CSE (instead of HIV, as previously) in South Africa and their intention and perceptions of implementing BtS during COVID-19 and its aftermath. We conducted the full survey before the exposure to the BtS training (excluding BtS implementation questions) and directly after the exposure to the BtS training (excluding teaching practice but adding implementation questions).

This data was collected before and directly after the BtS workshops. The survey/questionnaire was administered using paper versions of the questionnaire. Questionnaires and data were anonymized using participant identifiers (no names) and entered into Stata (and SPSS converted).

In addition, we used a short workshop evaluation form at the end of the workshop (appendix 3).

Table 3 Overview of scales and set of questions in adapted TSE-Q

Concept prompted	Measurement	Type of scale or question	No. of items	α
Demographics and school background				
Demographics	Original BtS questionnaire[44]	n/a	3	n/a
Teaching and school background	Original BtS questionnaire (self-developed)[44]	List choice	7	n/a
Teacher knowledge				
Knowledge about CSE in SA	Self-designed (new)	Binary (yes, no, don't know)	7	n/a
Disability and SRHR beliefs/attitudes				
Beliefs about disability and sexuality	Original BtS questionnaire (self-developed and adjusted after first validation)[44]	List of questions with 3-point Likert scale	7	0.7
Beliefs about disability and HIV risk	Original BtS questionnaire self-developed and adjusted after first validation)[44]	List of questions with 3-point Likert scale	7	0.7
Beliefs and practices in teaching CSE (practice only in pre-survey)				
Beliefs about what topics should be taught on: The Human Body and development	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 5-point Likert scale	5	0.85
Practise about what topics are taught at the school: The Human Body and Development	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 3-point Likert scale	5	0.86
Beliefs about what topics should be taught on: Relationships	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 5-point Likert scale	6	0.84
Practise about what topics are taught at the school: Relationships	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 3-point Likert scale	6	0.80
Beliefs about what topics should be taught on: Values, Rights and Personal Skills	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 5-point Likert scale	6	0.84
Practise about what topics are taught at the school: Values, Rights and staying safe	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 3-point Likert scale	6	0.80
Beliefs about what topics should be taught on Sexuality and Sexual Behaviour	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 5-point Likert scale	6	0.86
Practise about what topics are taught at the school: Sexuality and Sexual Behaviour	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 3-point Likert scale	6	0.86
Beliefs about what topics should be taught on: Sexual and reproductive health	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 5-point Likert scale	6	0.72
Practise about what topics are taught at the school: Sexual and reproductive health	Original BtS questionnaire which adapted scales to fit South African context from Howard-Barr[44]	List of topics with 3-point Likert scale	6	0.84



Concept prompted	Measurement	Type of scale or question	No. of items	α
Perceived Subjective Norms				
Perception of CSE from important others	Original BtS questionnaire which adapted scales to fit South African context from Mathew et al.[44]	List of topics with 5-point Likert scale	6	0.84
Self-Efficacy and Confidence				
Confidence to practise CSE and perception of teaching skills	Original BtS questionnaire which adapted scales to fit South African context from Mathew et al. [44]	List of topics with 5-point Likert scale	12	0,91
Material and professional preparation				
Perception of personal and school preparedness to implement CSE	Original BtS questionnaire (self-developed)[44]	Set of statements with 3-point Likert choices (not a scale)	12	n/a
COVID-19 implementation (only in post-survey)				
Intention to implement BtS	Self-designed (new)	Binary answers	1	n/a
Confidence to Implement CSE under or post COVID-19	Self-designed (new)	List of questions	7	n/a
Confidence to implement BtS teaching methods under or post COIVD-19	Self-designed (new)	List of questions	8	n/a
Perceptions of how to provide/adapt CSE during or post COVID-19	Open ended question self-designed (new)	Open ended questions	1	n/a

Objective 3 (O3)

In order to describe barriers and facilitators of implementing BtS as a whole school approach and under the current COVID-19 epidemic, we conducted short 30-60 minute key-informant interviews (KII) with 9 educators. The question guide for these KIIs prompted perceptions regarding CSE content, the BtS methods, and potential barriers and facilitators of implementing CSE with the BtS approach. In addition, we asked participants how CSE needs to be adapted during and post-COVID-19 and how learnt behaviour related to COVID-19 prevention interventions may impact social and multisensory learning needed to implement CSE.

This data was collected during the month following the BtS workshops. Participants were allowed to see the question guide before the interview to enable them to consult with their colleagues on some of the questions.

Interviews were audio-recorded and conducted in English. For each interview a debrief report was written summarising the interview and statements. Recordings were also uploaded into Microsoft Stream and automatically transcribed using speech recognition for English interviews and translated and transcribed by one of the researchers for any other language. Another researcher conducted the quality check of the transcriptions.

Objective 4 (O4)

In order to test the face and content validity of the TSE questionnaires, we asked educators to validate the TSE-Q with an adapted version of Rowe, Oxman and O'Brien's validity questionnaire (appendix 2).[49] This validity questionnaire has been used and adjusted to fit the context of CSE in South Africa in our previous study.[50] The questionnaire can be used to prompt face, content validity and ease of usage of the questionnaire. In addition, it tests whether the questionnaire makes sense on a basic level and can be used by the target population. Hence, it tests whether an instrument is meaningful to respondents.[51] Additionally, once the questionnaires were submitted, we allowed participants to provide additional verbal feedback. We also recalculated the Cronbach alphas (reliability testing) for each scale from our baseline study sample.

Analysis

Objective 1

In order to complete the situation analysis, we entered data in a self-designed mapping tool (Table 1). Then, we validated this content with the school management and CSE educators verbally and wrote a summary for the two schools.

Objective 2

We use descriptive statistics to describe the various scales and set of questions in the study. In addition, we developed a case report for each school. Beyond this report we will also conduct a regression analysis to identify which factors (knowledge, beliefs/attitudes, confidence, and resources) are associated with reported teaching behaviour if possible. As per Jenkins & Quintana-Ascencio (2020, A solution to minimum sample size for regressions), even with high variance, a sample of 25 is sufficient for accurate inferences.[58] Hence, as the sample size is limited by the available funding and time, we will establish if regression is possible with our small sample size when we have the data.

We provide a baseline for each school and determine which factors provide barriers and facilitators to implementing CSE at the participating schools. In addition, once the workshops were completed, we compared the pre- (baseline) and post-workshop surveys to understand if knowledge, beliefs, confidence, and access to resources have changed after the exposure to the BtS workshop. This comparison allowed us to identify if the workshop exposure could influence any barriers to CSE implementation.

We also describe the results of the workshop short evaluation data and provide a short overview of the outcome.

Objective 3

The KIIs were analysed using conventional content analysis and Jackson's collaborative method for qualitative studies.[39,52-54] The collaborative approach engages all research team members in the analysis process, including developing the coding framework and interpretation of the data. First, the research team read transcripts and individually and inductively identify main codes emerging from the data (conventional content analysis). Second, after a discussion, the team collaboratively developed a coding framework. In a third step, each transcript was coded separately by two researchers using the coding framework. Additional categories were added in consultation. NVIVO 12 was used as supporting software, enabling a check of data continuity and inter-coder reliability (this process will be run by one of the two researchers, and both researchers resolved conflicting coding afterwards collaboratively). Step four included the development of descriptive reports for each coding category (main emerging themes). For each theme, in-depth descriptions were developed with theme summaries. For the purpose of this report only snapshots and quotes are included to underline the educator's experience.

Objective 4

The content and face validation questionnaire was analysed with descriptive statistics. We also determined the Cronbach's Alphas for each of the questionnaire scales and adapted where needed. As per Bujang, Omar, & Baharum (2018, A Review on Sample Size Determination for Cronbach's Alpha Test: A Simple Guide for Researchers), a sample size of 30 and more is sufficient for determining Cronbach's Alpha.[59] In addition, we identified items that were not performing well and discussed the needed adaptations with some of the research participants.

Results

School Situational Analysis

Both schools had limited preparation and experience with providing CSE to their learners (Table 4). On the one hand in school A, two educators were trained and assigned to provide CSE and CSE was supposed to be implemented in the senior phases by these two educators. On the other hand, in school B, none of the educators were trained in delivering CSE. Any educator could include informal CSE lessons, which was only initiated when the learner raised issues related to sexuality. Both school's educators lacked adequate support for CSE and received little or no CSE training or resources. While in school A, educators were very reserved about implementing CSE at the project's onset; in school B, participants were eager to address this gap and extremely thankful that the BtS project was coming to their school.

Both schools had a School Governing Body (SGB), which comprised representatives from parents, educators, principal and support staff (therapists, nurses, hostel mothers). In school B, the SGB also included representatives from the disability community who supported CSE. Staff in School A had a very conservative attitude and were exposed to current anti-CSE propaganda through social media.[62] In both schools, the SGB was not involved in monitoring and guiding CSE. Furthermore, neither school had formal monitoring and evaluation structures or an internal guiding document on implementing CSE.

Curriculum and learning content

The term CSE is not used by the current school curriculum but fits within the topic of Life Skills (foundation and intermediate phase) and Life Orientation (senior phase). In both schools, educators make use of the mainstream Life Orientation (LO) and Life Skills (LS) textbooks, which include sexuality education topics but contain no suggestions or materials on how to adjust the content to meet the learning needs of those with disabilities. Officially, life skills for learners with disabilities is guided by the Differentiated National Curriculum and Assessment Policy Statement (CAPS) on Life Skills for Grades R-5[63]. This curriculum guide is written to accommodate learners of all age groups (5 years to 18 years) primarily with a severe intellectual disability but inclusive of learners with other 'developmental, functional, cognitive or behavioural challenges who are unable to access the 'mainstream' CAPS (Dept. of Education; 2017:5). As in the mainstream curriculum the provision of sexuality education within this differentiated curriculum is motivated by providing learners opportunities to practice life skills required to make informed choices regarding personal lifestyle, health, and social well-being (Life Skills, 2017:6). The differentiated curriculum briefly refers to an 'Adapted teaching methodology' to facilitate learning for individuals of differing abilities and encourages the educator to use Augmentative Alternative Communication (AAC) methods. Learning topics are broadly linked to age groups for example 'Me and my body' (excluding private body parts) (Grade R; ages 5 years to 7 years) 'Changes in boys and girls' (Grade 4 ages 14 years to 15 years) and Sexuality, Relationships and Friendships (Grade 5, ages 16 years to 18 years). As in the mainstream CAPS, curriculum topics are listed without guidance about how to achieve desired learning outcomes. Despite the provision of the Life Orientation curriculum and differentiated CAPS guidelines, sexuality education lessons in both schools were guided by a risk-protecting and abstinence approach encouraging learners not to engage in sexual activity but providing little information about human body development, sexual health, and behaviour. Furthermore, the adapted 2020 Content Phase Plans for Grade 4-6 and 7-9 due to COVID and lost teaching hours further restrict CSE related content to a mainly disease (COVID and HIV) and abuse prevention focus.

School B had links to a local disability organisation interested in supporting CSE for the learners at this school. This disability organization provides monthly sessions focusing on HIV and puberty, including an annual sexuality education camp. This camp is envisioned to provide a space in which learners can dive deeper into concepts relating to sexuality through various mediums. The written structure and materials from this course were, however, not available meaning that learning from these camps could not be further supported at the school level. Hence, despite having external organizations and educators claiming to conduct sexuality education, there was no formal, targeted, and structured implementation and delivery of CSE at school B and educators said that they 'used summarized extracts from government-issued textbooks and the LO curriculum'[63]. Similarly, in school A's there was no formal, or structured implementation, however, two dedicated and trained educators provided CSE lessons without further support from other teachers or community members.

In school B, CSE topics were chosen ad hoc and in response to educator observations and perceived needs of learners (examples included sexual activity at school). CSE was more formalised in school A but focused on perceived "soft topics" (decision making skills, assertiveness skills, staying safe, relationships, values and rights, puberty, male and female sexual development, problem solving,

gender norms and equality, romantic relationships, HIV and reducing stigma and HIV testing and treatment) were implemented. Similarly, in school B, participants felt adequately prepared to handle "soft topics", such as family and having children, while perceived "hard topics", such as 'masturbation' were referred to the disability organisation outside of the school context. CSE content in both schools was provided in single-sex lessons, which were perceived as safer and indicate a narrow understanding of CSE focusing on body development and sexual behaviour. Participating educators in school B understood single-sex groups as creating space for fluid discussions wherein learners are not conscious of the opposite sex. In school B, CSE sessions were also provided by a teacher of the same sex, while in school A, both boys and girls were taught by female teachers.

Parental involvement

There was little to no involvement and consultation with parents and caregivers in both schools regarding implementing the CSE component of Life Skills. Participants reported that parents are consulted when issues arise, e.g. learners are practising sexual behaviour on school property or when educators discover teenage pregnancy. However, participants reported that often parents were unavailable to engage in CSE delivery as many live far away or do not respond for unknown reasons. Overall, "sexuality" was a taboo topic in the communities of both schools, and participants felt that this leads to parents avoiding the topic of sexuality with their children. Participants reported that for the Deaf, this is further exacerbated by the fact that parents are often not proficient in sign language, and therefore struggle to communicate with their children. On the one hand participating educators reported that some deaf learners ('the Deaf') revealed during informal discussions that they would be beaten if they "talk" about or ask parents about sexuality at home. On the other hand, participants also reported that some parents, who were aware that their child is sexually active, ask educators to speak to their child on their behalf.

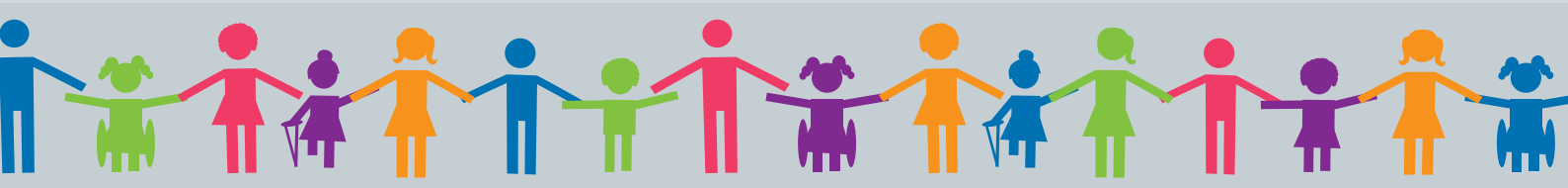
Participants also reported that some parents of 'deaf' girls "blame older boys" for their sexual debut, not understanding that their daughter is already at the stage where she is interested in sexual activity. According to participating educators, this is underpinned by cultural and religious discourses of patriarchy, purity, and chastity, "painting" girls with disabilities as "innocent children". Consequently, girls with disabilities are constructed as asexual, infantile, and lacking sexual agency. Simultaneously, learners with intellectual disabilities were sometimes also perceived as oversexed if they display sexual activity in public places. These public displays are punished without any information on where the sexual activity might be appropriate. The living arrangements of school hostels had little to no private space for learners, making it impossible to identify an 'appropriate' place or time for masturbation, or teach age appropriate boundaries related to personal hygiene and toileting.

Based on the restrictive socio-cultural interpretation of sexuality, gender, and disability and the limited private space and the lack of skills and resources among educators, sexuality education was constructed within a protective discourse using a risk-abstinence approach in both schools before the BtS training.

Educator support needs and learner abuse

In both schools, the need for educator training and support was expressed. Participants stated that they lacked adequate resources and integrated SRH services to support learners. Several participating educators expressed feeling the "weight" of the lack of training and support when handling cases of sexual abuse. Participants in school B described examples of sexual abuse by family members. The school reports such cases, but participants reported that learners do not always understand that sexual activity between them and an adult is inappropriate or that their family is financially dependent on the perpetrator. Hence, learners can experience emotional or financial loss when a perpetrator is reported. In addition, their families are often against reporting, which sometimes results in the learner not returning to school when these cases are reported.

One participant elaborated on the internal turmoil of reporting cases of abuse perpetrated by the primary breadwinner. The participant reflected that educators know their duty to report violence and abuse; however, they are also "aware of the domino effect" when the primary breadwinner is removed from a household. Participants explained that once a breadwinner is removed from the home, learners stop coming to school as they have no more money to travel to school. Alternatively, other adults in the house will seek work and cannot accompany the child with disability to public transport. In other cases, learners are removed from school and are made to go and work. Participants also suspected that in some cases, the disability is used to access resources (e.g. disability or care grants) for the whole family and not geared towards the successful development and care of the person with disability. Hence, participants reflected that the person with disability "is seen as a financial means to an end". They suspected that coupled with caregiver burnout, learners with disabilities may experience increased abuse and not come to school anymore. Hence, participants reflected that educators need to address sexuality and violence and abuse among their learners without causing further harm.

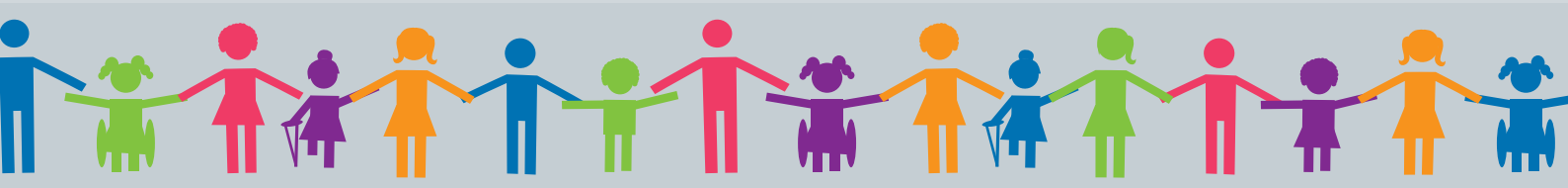


Hence, participants reported that educators felt unqualified and unsupported when handling cases of sexual abuse and expressed a dire need for social workers to be more vigilant in following up on cases of abuse or violence. Participants from school B confirmed that adolescent and youth with disabilities were very vulnerable to abuse and saw people in their communities viewing young people with disabilities as easy targets who will not be believed when speaking up about the abuse because they have a disability. Participants in school A were initially more hesitant to talk about the abuse of learners with disabilities. However, after continued engagement with the school, participants revealed that their learners are very vulnerable. In fact, the topic of violence and abuse of learners with disabilities became a central discussion point with the participants from this school during the BtS workshop.

Table 4 Results of School Situation Analysis

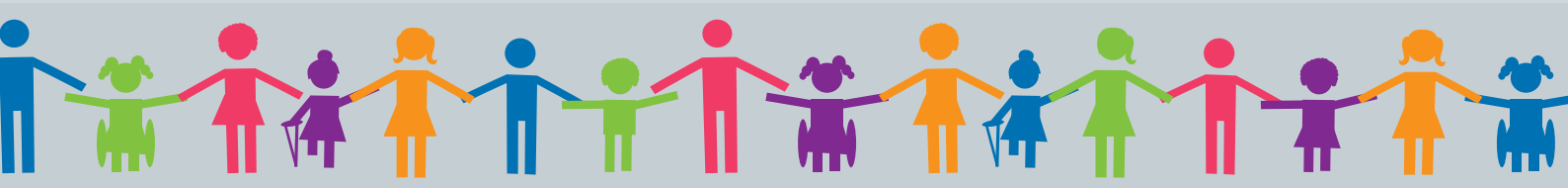
Item prompted	School A	School B
School and Community Environment		
National Curricula and resources guiding CSE	DOE CAPS for Life Orientation (LO) Grade R-5 Differentiated CAPS 2017 Life Orientation (LO) Learning programme Revised Curriculum the 2020 National Content Maps grade 4-6 (both copies retrieved). 2020 CAPs reduced CSE related topics and focuses on safety, child abuse, COVID and HIV and AIDS.	DOE CAPS Life Skills (LS), Life Orientation (LO) and DCCT formulated CSE. Life Skills (LS): Grade R-5 Differentiated CAPS 2017 Orientation Learning Programme Life Orientation (LO) textbook is used to guide educators from grade 7 onwards. Educators pick and choose different extracts that are then combined.
School internal documents guiding CSE	No documents focus on CSE. Learners code of conduct exists.	No documents focus on CSE. Learners code of conduct exists, which deals, among other things, with sexual violence on school's premises
Involvement and consultation with parents and caregivers (house mothers) about CSE	No formal or informal consultation about CSE with parents/caregivers has taken place in this school Parents are consulted when issues arise. However, in general, parents are seldom involved in the school as they live far away.	Some informal consultations have taken place with parents in this school. Educators perceive parents as not focusing on the provision of sexuality education. As a result, the school conducted parent support group sessions. In those concerns were raised about learners' behaviour, but not access to sexuality education.
Parent/ caregiver's and community member's response to the provision of sexuality education	There has never been a request or comment about CSE from the community or parents/caregivers. Sexuality is a taboo topic in this community.	Sexuality is taboo in this community. Therefore, there is no discussion between educators and parents/ community regarding the provision of CSE. However, educators get a sense that there is an unspoken appreciation that they are teaching CSE.

Item prompted	School A	School B
Referrals of learners who need SRHR services	The school refers to: 1) sexual violence or abuse to Thuthuzela Care Centres, social worker appointed by DOE for the school and school nurse appointed this year, 2) local primary health clinic (but only non SRH related services such as check-ups for learners, e.g. for eyes and ears). Educators reported that all SRH related conditions and needs have to be addressed by parents/legal guardian since regulation changes in 2016 but could not name the regulation changes During the first visit, some educators in this school claimed that they do not have SRH challenges such as teenage pregnancy and sexual violence or abuse among their learners. However, this changed after learners returned to school from January 2021 onwards, with teachers noticing new behaviour with a sexual connotation.	The school refers to: 1) sexual violence or abuse to the social worker and DBE (form 21) (there is an underlying assumption that SRH services "are defined as services to assist the reporting of sexual abuse/violence"), 2) there are no further referrals to any other SRH services. Educators reported that in the past, only parents were notified. However, some families would *"sweep it [sexual violence] under the carpet as it is all about financial support"*. The educators report that typically learners are abused by a family member; hence when parents are notified, they do not act, as they are the perpetrators or financially dependent on the perpetrator.
Socio-cultural barriers and enablers impacting implementation ofc CSE (educators, parents, or community members)	Participants revealed that some teachers are very conservative and hesitant to implement CSE. They are also nervous about the BtS project. Some educators are exposed to conservative propaganda such as the anti-CSE videos and communication from Dr Arthur Frost, pastor at Digital Church: https://fatherheart.co.za/. In addition, 10 of the invited participants from this school did not come to the BtS workshop, and informal information indicated that these staff members were opposed to CSE. No barriers were reported from parents or community members before the BtS workshops.	Participants explained that educators are very relieved that BtS is coming to their school. They also reported that community attitudes towards sex/ sexual activity/sexuality frame these topics as taboo. Therefore, parents are not comfortable discussing sexuality with their children. This discomfort is further exacerbated by the fact that parents are not proficient in sign language and therefore struggle to communicate with the Deaf. According to participants, during the informal CSE sessions, their learners reveal that they would be beaten if they talk/sign/ask parents about sexuality at home. Educators also revealed that if parents are aware that their children are sexually active, they ask educators to speak to the child. Parents of female learners also "blame older boys" for their sexual debut, not understanding that their daughter is already at the stage where she is interested in sexual activity. According to participants, this is underpinned by cultural and religious discourses of feminine purity and chastity, contextualized within perspectives on disability. Such perspectives view people with disabilities as asexual.
CSE Leadership and Guidance		
School governing body	The school has a School Governing Body (SGB) that includes parents, educators, principal and support staff (therapists, nurses, hostel mothers). This body is not involved in CSE.	The school has a School Governing Body (SGB) that includes parents, educators, principal and support staff (therapists, nurses, hostel mothers).



Item prompted	School A	School B
Educators leading CSE implementation	Two experienced female teachers have been assigned to spearhead CSE. These two educators have been exposed to BtS before.	The Deaf Community in this area conducts monthly sexuality education sessions. These sessions are from an outside organisation; hence they do not form part of the school's staff. Sessions usually take place on school property. These sessions are paired with an annual camp, wherein learners partake in skits that demonstrate concepts of sexuality education. These skits are said to help learners better understand the curriculum. Life Skills educators of the school also provide supplementary sexuality education based on observations of learners, e.g. if learners start discussing sexual acts, then some educators will discuss the arising issues with the class.
Staff delivering CSE and resources	The two teachers assigned to lead CSE also provide CSE. Many educators in this school do not want to teach CSE and leave it to the two assigned teachers. The two CSE teachers have access to the draft BtS comprehensive guide and essential lessons.	Educators deliver CSE individually when issues arise. One educator explained that he teaches CSE by observing and listening to what the boys in his class discuss.
Monitoring implementation of CSE	There is no specific monitoring of CSE. It is implemented as part of LO. However, the school has some sample lesson plans (soft topics) which could assist in developing LO monitoring.	There is no formal monitoring of CSE implementation in place, and there are no sample lesson plans.
School Curriculum		
Inclusion of CSE as part of the curriculum	CSE is implemented as part of Life Skills (LS) and Life Orientation (LO), grade R-5 curriculum and CAPS (2017)	CSE is implemented as part of Life Skills (LS) grade R-5 curriculum and Life Orientation (LO) for senior grades - CAPS (2017)
Learning topics that are part of this CSE curriculum	According to the educator's part of the L/O curriculum includes: Foundation phase- Body parts and disease Intermediate phase- Relationships and diseases	According to the educator's part of the LS curriculum includes: 1) Development of Self in Society: Relationships and Friendships: Sexuality 2) Health, Social and Environmental Responsibility: Decision Making about Health and Safety
CSE and learning phases	This school teaches CSE only in the senior phase	CSE is delivered starting in grade 5. Boys and girls are split into separate sessions, including the educator leading the session. Hence, female learners are taught by a female educator as they feel this is a more appropriate setting to discuss puberty and sexuality.
Educator Training and Support		
CSE training of educators (content, timeframes and year)?	Two teachers were part of the training for BtS CSE and had the comprehensive draft guide and essential lessons The same two teachers and one additional one received general CSE training from DOE (2-hour session). No resources are available from this DOE training. Educators could not recall the title of the training.	None of the educators had any specific CSE training. LO Textbooks serve as a basic guideline.

Item prompted	School A	School B
Implementation of CSE curriculum	Educators follow the L/O, grade R-5 curriculum There is some structured time set aside for CSE – but under COVID 19, this was taken out as per government LO adjustments for the year.	Implementation of CSE is informal and different extracts of textbooks (LO & LS) guide the implementation. Extracts are chosen based on what the educator observes and perceives as needed. Hence, CSE is delivered according to what educators observe, what learners speak/sign about, thinking or enacting. For example, learners have simulated performing sexual intercourse. The educator then knew it was time to a) discuss this and b) escalate the matter to the principal. The majority of the CSE delivered by educators is risk-abstinence based. Hence it covers the "soft" topics. These sessions are informally guided by extracts taken from the LS textbook. There is no formal lesson time for teaching CSE and perceived "hard topics" of sexuality education, e.g. masturbation. Are given to DCCT and/or social workers to handle. Documents for these lessons are not available at the school.
Issues that educators are responding to	Gender-based violence, pregnancy (main topic), difficulties in informing, love relationships (premature relationships).	Learners bring core issues to educators, e.g. a young female student approached one educator stating that she knew of other learners who were sexually active. The learner then asked the educator about sexual intercourse and whether or not it was something she could do.
Educator support for CSE curriculum implementation	There is no support; educators implement on their own accord.	There is no support; educators implement on their own accord.
Available tools and resources		
CSE resources available at the school	Mainstream LO curriculum and BtS draft comprehensive guide and essential lessons	LO & LS textbook, DCCT Camp wherein learners are given CSE using drama and visual resources. Unfortunately, resources are not available at the school.
Needed resources to implement CSE in this school	Participant identified: teaching aids, Assistive Emotional Communication (AEC) devices to assist learners who have difficulties in speech as needed resources for CSE	Participants identified as needed resources for CSE: – Material designed for young people with disabilities – Dedicated staff in the form of a part-time social worker or psychologist stationed at the school. – There is a social worker assigned to the school. However, educators feel they are not accessible. Essentially, resources are known but cannot be easily accessed.
Other support needed	Infrastructure upgrade, currently there are more classrooms needed, and the school is under construction	Educator training for CSE; List of resources, e.g. essential phone numbers/ organisations that can be contacted in an emergency (and just in general). Part-time social worker/psychologist stationed at school.



Educator and Support Staff Preparedness before BtS Training

Overall, 50 educators, support staff and NGO members participated in the two schools baseline survey (tables 5a-h). The baseline sample included 22 support staff (housemothers, healthcare staff, and NGO members) and 28 educators. Most participants were of the Christian faith. Age and number of years of teaching experience varied (table 5a). Seventeen of the participants were involved in teaching Life Orientation, including CSE. Eight participants had previous training in CSE (which is higher than the reports from the needs assessment).

Table 5a Demographics of Baseline Survey Participants

	Level	School A	School B	Overall
Number of participants		25	25	50
Age group	20-30 years	1 (4.0)	4 (16.0)	5 (10.0)
	31-40 years	7 (28.0)	8 (32.0)	15 (30.0)
	41-50 years	8 (32.0)	9 (36.0)	17 (34.0)
	51-60 years	8 (32.0)	3 (12.0)	11 (22.0)
	60 years and above	1 (4.0)	1 (4.0)	2 (4.0)
Gender	Female	25 (100.0)	21 (84.0)	46 (92.0)
	Male	0 (0.0)	4 (16.0)	4 (8.0)
Religion	Catholic	2 (8.0)	6 (24.0)	8 (16.0)
	Hindu	3 (12.0)	0 (0.0)	3 (6.0)
	Islamic	1 (4.0)	0 (0.0)	1 (2.0)
	None	0 (0.0)	2 (8.0)	2 (4.0)
	Other	1 (4.0)	2 (8.0)	3 (6.0)
	Protestant	18 (72.0)	9 (36.0)	27 (54.0)
	Prefer not to answer	0 (0.0)	6 (24.0)	6 (12.0)
Years of teaching	Support staff not teaching	10 (40.0)	12 (48.0)	22 (44.0)
	Trainee	1 (4.0)	1 (4.0)	2 (4.0)
	1-3 years	3 (12.0)	0 (0.0)	3 (6.0)
	4-10 years	6 (24.0)	3 (12.0)	9 (18.0)
	more than 10 years	5 (20.0)	9 (36.0)	14 (28.0)
Teaches LO or sexuality education	No	7 (28.0)	4 (16.0)	11 (22.0)
	Yes	8 (32.0)	9 (36.0)	17 (34.0)
	NA	10 (40.0)	12 (48.0)	22 (44.0)
Formal training in LO or sexuality education	No	3 (12.0)	6 (24.0)	9 (18.0)
	Yes	5 (20.0)	3 (12.0)	8 (16.0)
	NA	17 (68.0)	16 (64.0)	33 (66.0)

Participants knowledge about CSE policies and regulations varied (table 5b, appendix 4). Half of the participants knew that CSE (as part of the Life Orientation curriculum) is a standard policy for teaching learners at school supported by the DoE. Part of the challenges here for educators is the fact that CSE is embedded in Life orientation and Life skills programme, which means they may not always notice that they are already required to teach CSE[63]. Most participants knew about their duty to teach learners about SRH rights, gender equality and HIV. At the same time, there was uncertainty about policies and whether it was permissible to talk about sexual intercourse, show diagrams of a vagina, and talk about sensitive topics such as homosexuality or masturbation.

Overall, most participants knew that CSE had a positive impact on learner's self-confidence and skills to report violence (82%), acceptance of different sexual orientations and gender identifies (74%) and increased condom use and usage of contraceptives when needed (62%) (table 5c, appendix 4). However, a large number of participants held false beliefs about the impact of CSE on sexual activity. These participants believed CSE sexualizes children (38%) or were unsure about it (32%). Furthermore, 36% of the sample believed that CSE entices learner's sexual activity and risk-taking, and 36% were unsure. Similarly, 26% believed that CSE would encourage learners to practice masturbation, while 40% of the participants were unsure.

Regarding the intersection of disability and sexuality, most participants believed that their learners could not understand sexuality (80%) and were hyper- or oversexed (62%). Approximately a third of the participants believed that their learners were able to engage in sexual activities (38%), could make sexual choices (26%), negotiate the use of condoms (22%) or form a family (32%). The rest of the participants were uncertain or did not believe the learners could perform these activities or make these choices (table 5d, appendix 4). However, many of the participants saw their learners exposed to well-known HIV risk factors such as the risk of sexual abuse (80%), insufficient knowledge about HIV and AIDS (68%) and information about the disease (66%), unprotected sex (74%), usage of cannabis or alcohol (38%) and having more than one partner (44%) (table 5d, appendix 4).

The TSE-Q also prompted teaching beliefs and practice/behaviour in different CSE topics (table 5e, appendix 4). This prompting includes five main domains: Human Development, Relationships, Personal Skills & Wellbeing, Sexual Behaviour and Sexual Health. In all five domains, the belief that a specific topic should be taught (agreement A, SA) was much higher than the actual teaching of the topic (see graphs 1-10). At the workshop over 80% of educators agreed to teach about domains of personal skills and relationships and the sub-topics of abstinence, sexual transmitted diseases (STIs), sexual abuse and reproductive health.

The greatest difference between teaching beliefs and practice/behaviour was observed in sexual behaviour and sexual health. Soft topics related to a) personal skills including assertiveness, decision making, values, looking for help, negotiation and communication and b) relationships such as friendship, family and love were the most common topics implemented in existing lessons (half of the participants). Some participants also covered body image, puberty, sexually transmitted diseases, and sexual abuse. However, topics falling under sexual health or behaviour and reproductive anatomy and function, dating, marriage and having children were seldom covered by participants.

Overall, a large portion of participants knew that many different stakeholders expect them to teach CSE, such as learners (70%), the governing body (68%), other educators teaching LO (66%), educators teaching other subjects (64%) and external experts (42%) (table 5f appendix 4). On the one hand, participants expressed confidence to perform most of the required teaching techniques needed for CSE implementation (table 5g, appendix 4). On the other hand, participants' responses revealed a significant lack of CSE material and linkage to SRHR services and different opinions about the available resources at their schools (table 5h, appendix 4). Although, 64% of the participants felt that some HIV and sexuality education material was available at their school, over a third indicated no material at all, and 44% believed that the material was not suitable for their learners. Hence, 56% of the participants said they need material suitable for their learners to teach about HIV or sexuality. Opinions also varied about if schools offer HIV counselling, counselling for sexual abuse and linkages to mainstream HIV-awareness campaigns, child protection services and involvement of parents/caregivers (table 5h, appendix 4).

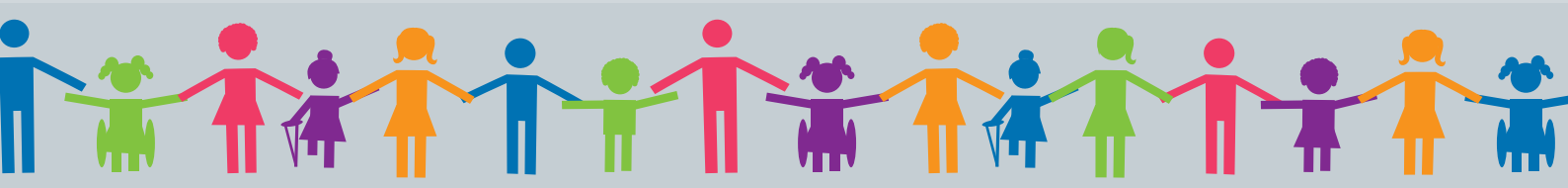
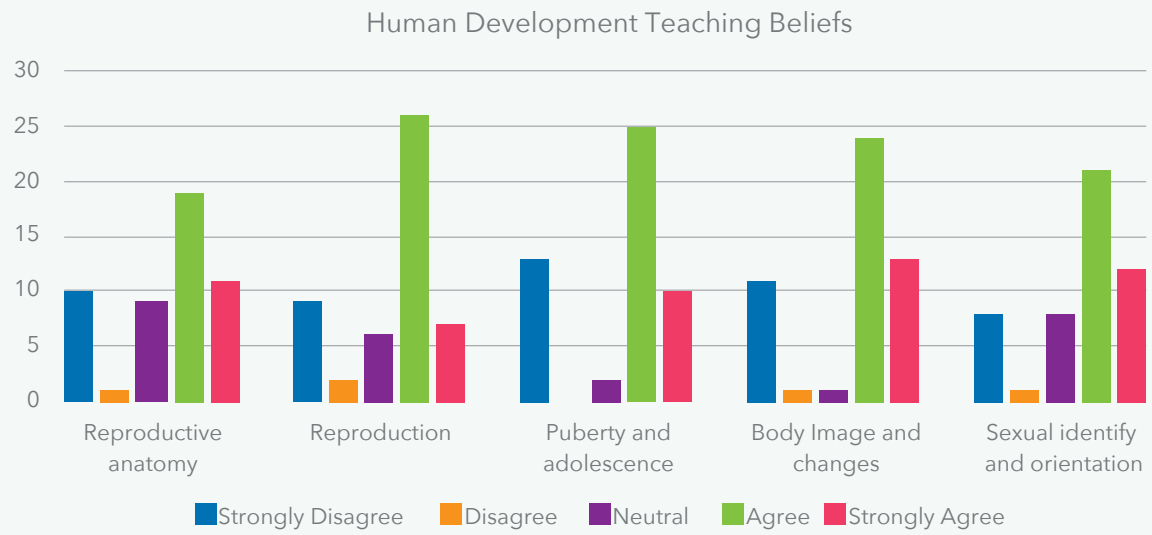
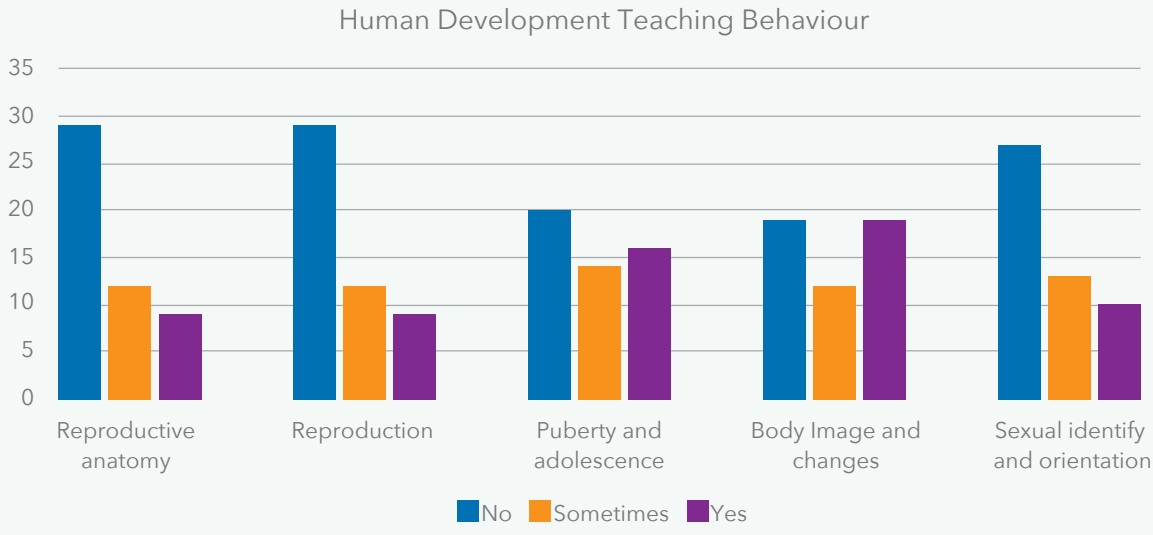
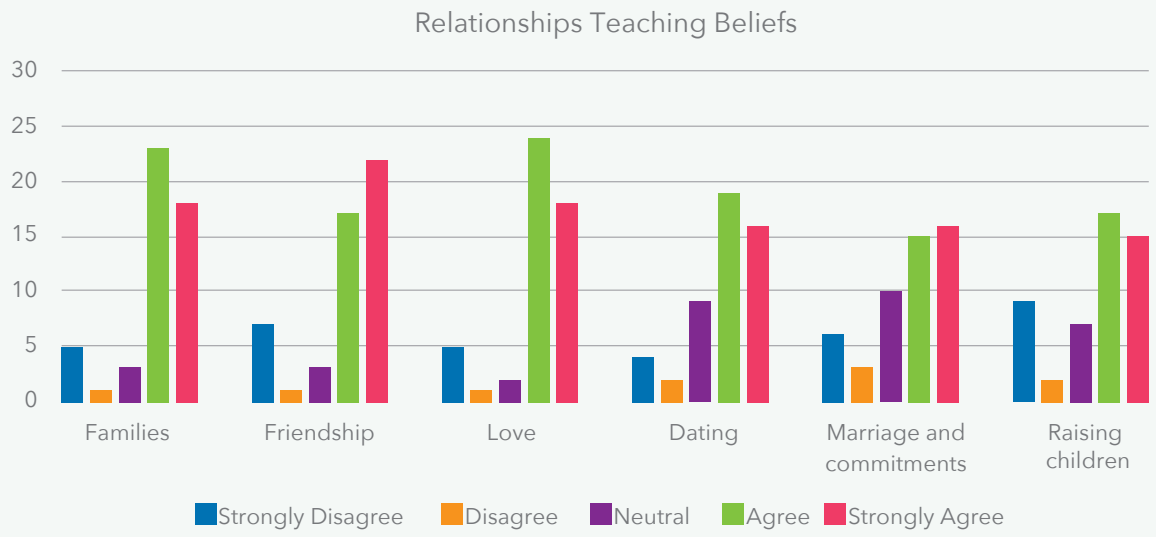


Figure 5 Breaking the Silence approach to CSE






Relationships Teaching Beliefs
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25
20
15
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5
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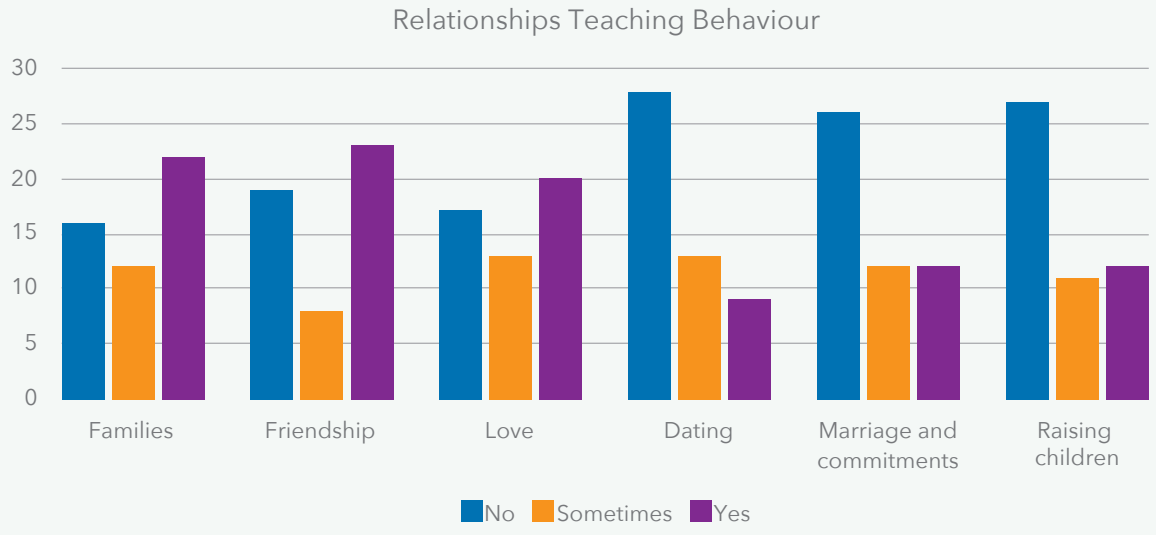
Families
Friendship
Love
Dating
Marriage and commitments
Raising children
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree


Relationships Teaching Behaviour
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Families
Friendship
Love
Dating
Marriage and commitments
Raising children
No
Sometimes
Yes

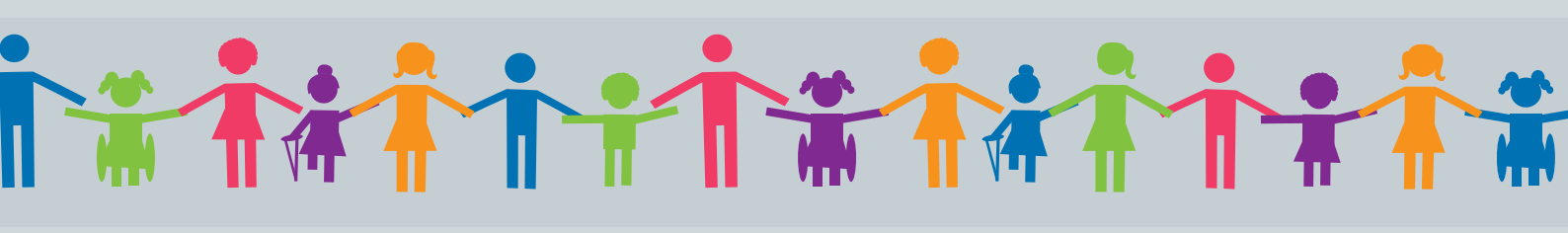
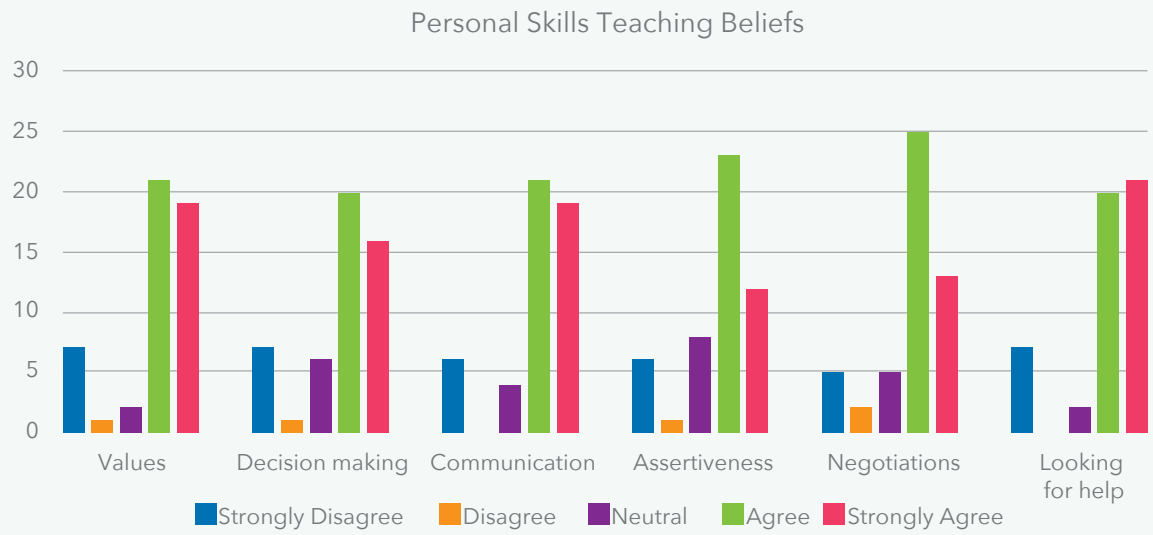
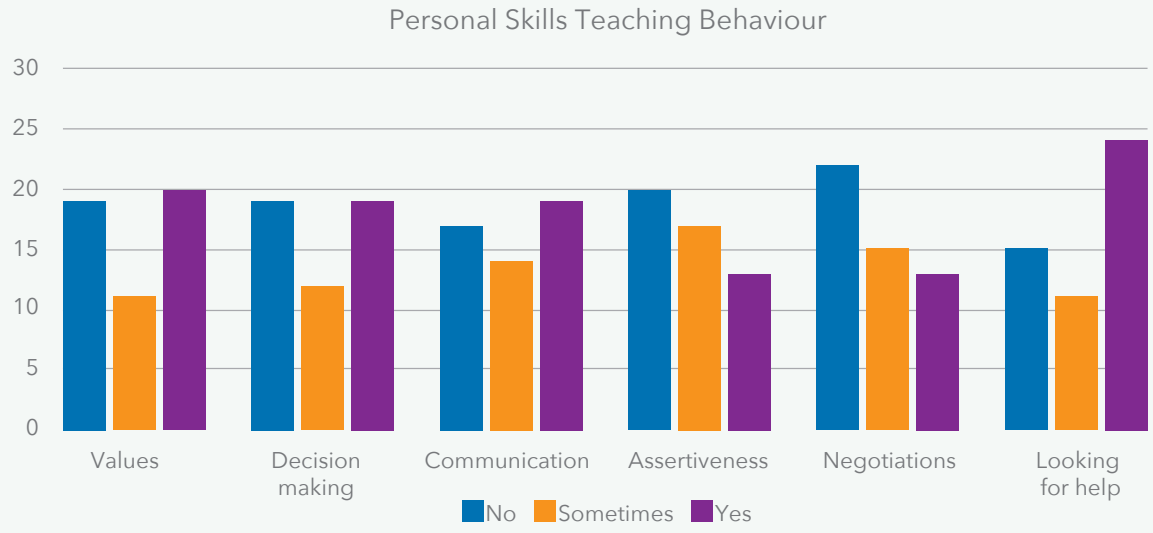
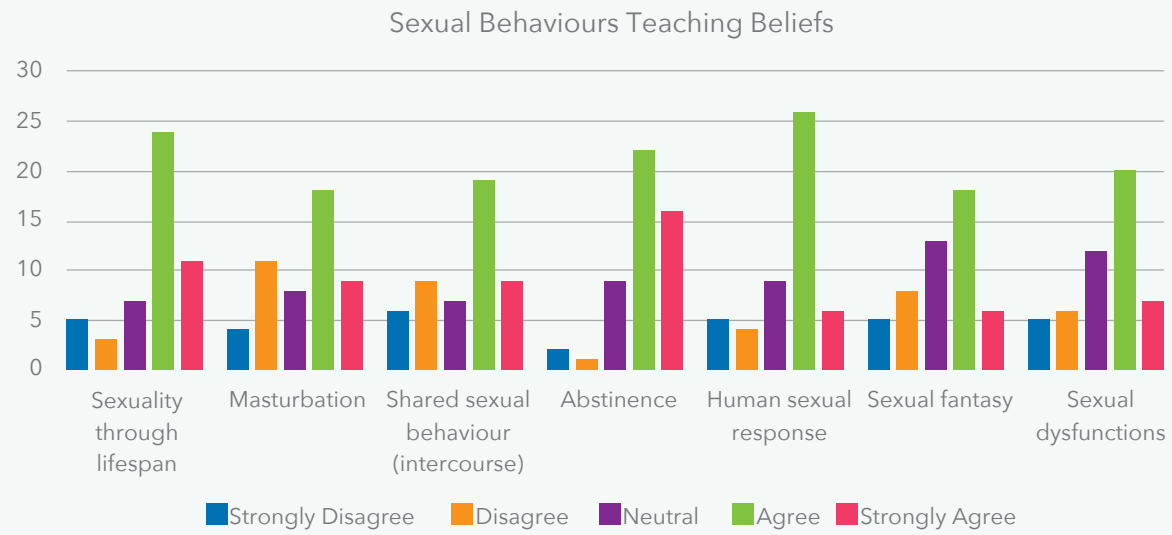


Figure 5 Breaking the Silence Approach to CSE (continues)






Sexual Behaviours Teaching Beliefs
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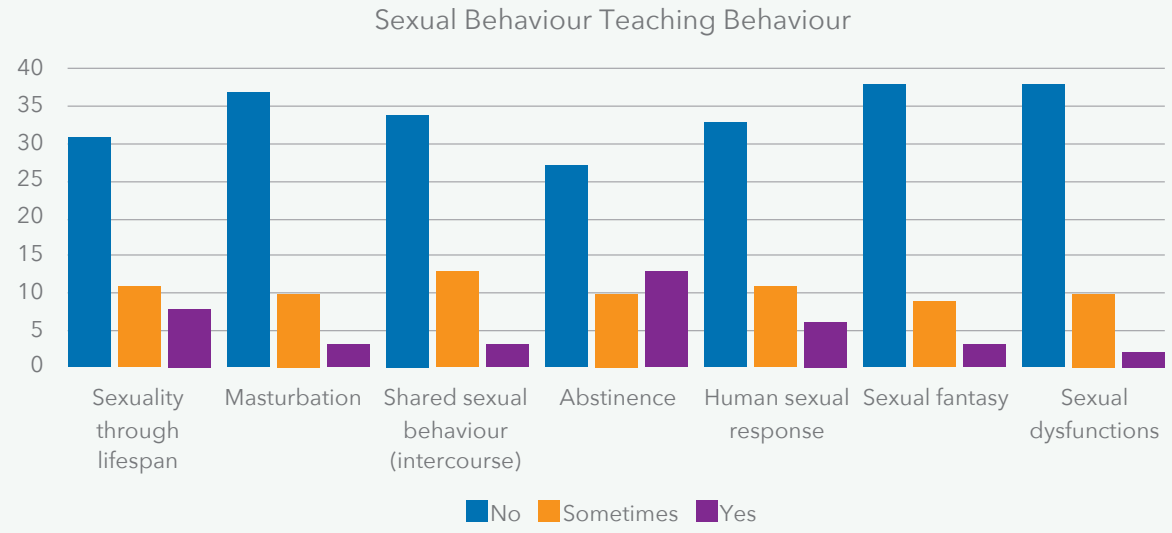
Sexuality through lifespan
Masturbation
Shared sexual behaviour (intercourse)
Abstinence
Human sexual response
Sexual fantasy
Sexual dysfunctions
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree


Sexual Behaviour Teaching Behaviour
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Sexuality through lifespan
Masturbation
Shared sexual behaviour (intercourse)
Abstinence
Human sexual response
Sexual fantasy
Sexual dysfunctions
No
Sometimes
Yes

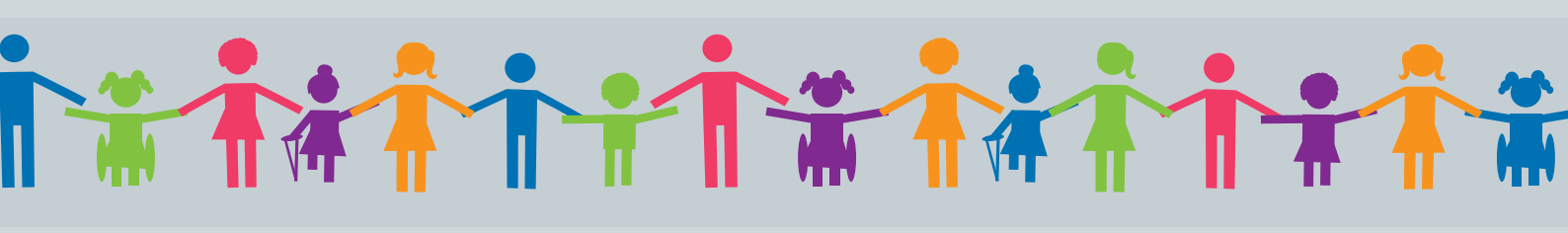
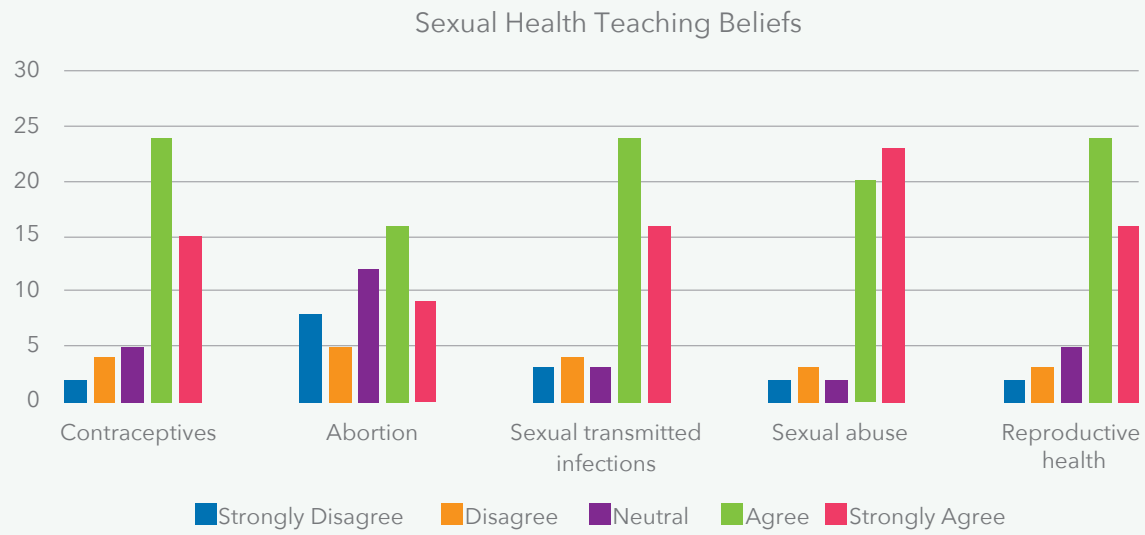
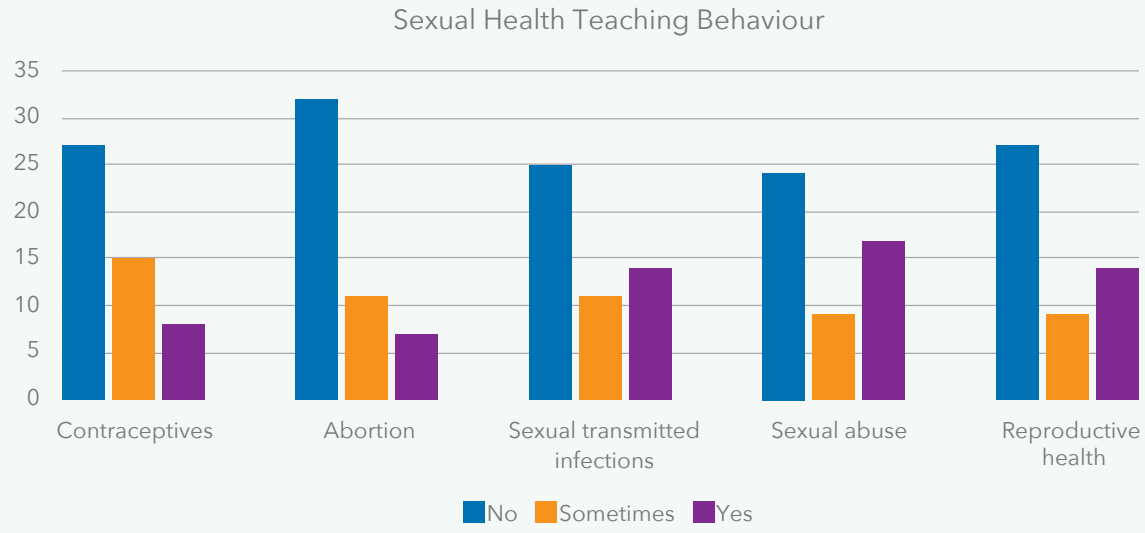


Figure 5 Breaking the Silence approach to CSE (continues)





Preparedness of Staff post-BtS Training Workshops

Out of the 50 pre-workshop participants, 26 participated in the BtS workshop and post-workshop survey with the TSE-Q. Interviews revealed that some educators could not participate on the training dates as they were looking after learners (COVID regulations pushed the workshops into school terms) or were simply against CSE and therefore not participating in the workshop.

The TSE-Q post-workshop survey revealed that many items on the CSE knowledge, CSE beliefs, beliefs about disability and sexuality, and CSE teaching beliefs questions improved for the participants who participated in the workshop (table 6a-f). However, some items also did not change (often because baseline scores were already good). Some items became slightly worse, and two questions in the CSE knowledge section were identified as misleading, resulting in wrong answers (please see under validation of questionnaire in next chapter).

CSE knowledge

Although the BtS workshops and material focus on CSE teaching methods and implementation, they also included some information and discussion on CSE policy. Overall knowledge on CSE policy requiring educators to teach about gender equity, equal relationships, sensitive topics such as homosexuality and masturbation and sexual and reproductive health and rights improved for the participating educators, while knowledge about CSE being a standards policy had mixed results (Appendix 5, Table 6a). The two questions about providing information on sexual intercourse and showing a diagram of a vagina were misleading and cannot be used for the post-intervention survey (see validation of questionnaire).

CSE Beliefs

Although CSE beliefs are not the focus of the BtS workshops, some discussion on the purpose and impact of CSE is included. Overall, the participating educators held fewer misconceptions about CSE post the BtS workshops. For example, fewer educators believed that CSE sexualizes children and adolescents, entices learner's sexual activity and risk-taking or encourages learners to practice masturbation (Appendix 5, table 6b). Instead, more educators agreed that CSE increases learners' self-confidence and ability to report violence and increases learners' tolerance towards different sexual orientations and gender identities. The question on contraceptives had no change but was already relatively high at baseline.

In the post workshop interviews participants emphasized the change in their beliefs about CSE and the power of the BtS approach to enable them to speak about topics related to the body, relationships and sexuality.

> *"The BtS approach not only broke the silence but some views and beliefs"*
>
> Workshop participant post intervention interview

Participants also re-emphasised on the need to provide CSE and their responsibilities to help breaking the silence on a difficult topic.

> *"We have to do it [CSE], this silence need to be broken one way or another."*
>
> Workshop participant post intervention interview

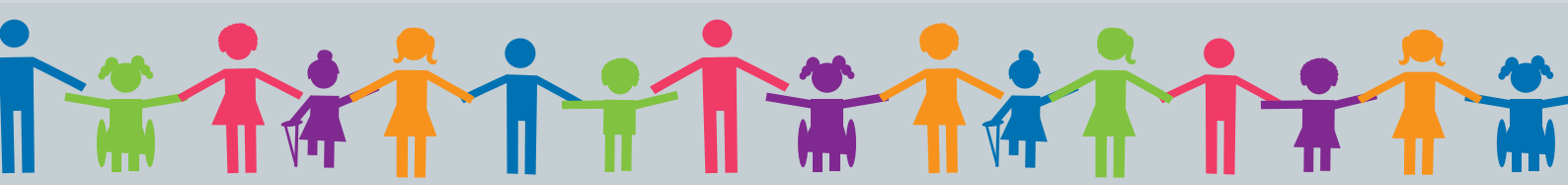
> *"It [sexuality] is something that we cannot hide or put under the carpet."*
>
> Workshop participant post intervention interview

Participants reflected on the fact that their ***"learners are in the dark' and need to be empowered to speak about abuse even if this happens in the home as they "are currently not aware of what was happening they thought they should keep it a secret".***

Participants also reflected on their perceptions before the workshop and those of other educators who did not attend the workshop which included views such as that: 'CSE is teaching learners how to have sex', 'what sexual activities are all about', 'homosexual activities', or 'different styles of having sex'. Hence, several participants mentioned that their views had changed after attending the workshop and noticed that this had happened to other participants from the conversations that were held prior and post the workshop.

> *"They [the participants] had a better understanding afterwards [after the workshops] because before it [CSE] was just a taboo subject"*
>
> Workshop participant post intervention interview

> *"I am very happy and I am relieved. I am thankful to have attended the workshop I have gained so much knowledge on CSE, at first I thought talking to the learner about sex would have meant that I am harassing them."*
>
> Workshop participant post intervention interview



> *By the end of the first day of the workshop there was already a shift in our ways of thinking and our views on the CSE curriculum and BtS*
>
> *Workshop participant post intervention interview*

Beliefs about Disability and Sexuality

The BtS workshops included discussions and information on disability and sexuality. Overall, the educator's beliefs about disability and sexuality included fewer misconceptions about learners with disabilities and their sexuality. For example, more educators disagreed that learners cannot engage in sexual activity, are hypersexual or oversexed, cannot learn how to negotiate the use of condoms, form a family or are unattractive (Appendix 5, table 6c).

In the post-workshop interviews participants easily acknowledged the fact that their learners were already exposed to sexual information and that some were sexually active or exposed to abuse and therefore in need of information about sexuality.

> *It [sexuality] is a daily issue – it comes up daily now that we have particularly a lot of teenagers. There are often relationships developing at school between children. Before [the workshops] we had a culture of just stopping the relationships, keeping them separate. Now there is a sense that this is real. It happens here as it is happening at home. And now we really need to face this*
>
> *Workshop participant post intervention interview*

Beliefs about HIV-risk

Similarly, HIV-risk for learners with disabilities was discussed in the workshops. At baseline, educators were already quite aware of the HIV risk of their learners. Hence, most items on this scale stayed constant, with slightly more educators agreeing that their learners could identify their HIV risk and have more than one partner, while less educators identified the sexual abuse risk. However, in the post workshop interviews all educators reflected on the risk of sexual violence and abuse and their dire need to support their learners.

> *Sometimes you find that when you conduct research based on their change of behavior it is revealed that previous or prior abuse is now troubling the child or even maybe something has happened while at home. Dealing with the aftermath of these cases that's where the BtS approach can come in*
>
> *Workshop participant post intervention interview*

Teaching Beliefs

BtS includes an intensive engagement with teaching methods on different CSE topics and how teaching methods need to be adapted to support the learning needs of learners with different types of disabilities (universal design and reasonable accommodation). The post-workshop survey included the teaching belief scales of the TSE-Q. These reveal that for several items, teaching beliefs improved, while for some, there was little change (positive or negative).

For the domain of human development, more educators agreed that their CSE lessons should include information on reproductive anatomy, reproduction, puberty and adolescence, body image and changes, and sexual identity and orientation (Appendix 5, Table 6d). In the relationship domain, more educators agreed that they should include information on friendship and dating. In contrast, information on families, love, marriage/ commitments and raising children had mixed results (Appendix 5, Table 6d). For the domain of personal skills, more educators agreed that they should teach about values, decision-making, communication, assertiveness, negotiations, and looking for help (Appendix 5, Table 6d). Under the sexual behaviour scale, more educators agreed that they should provide information on masturbation, the human sexual response, sexual fantasy and sexual dysfunctions.

After the workshop, fewer educators thought that they should teach about sexual behaviour throughout the lifespan or that they should teach about abstinence. The latter might indicate a move away from the risk-protection and abstinence-only focus of sexual education (Appendix 5, Table 6d). Lastly, the sexual health domain results were mixed with no major changes in most items (some already had a high agreement at baseline such as STIs, sexual abuse and reproductive health). More educators believed that they do not need to teach about contraceptives, which indicates that this item might have to be strengthened in the BtS workshops.

Confidence to Teach CSE Core Concepts during and after COVID-19

This feasibility study was undertaken at the beginning of 2021, just after the height of the second COVID-19 wave in South Africa. The post-workshop survey included questions around the feasibility of implementing the BtS approach and teaching CSE core concepts during and after the COVID-19 epidemic. This included a set of questions prompting educator's confidence to teach the 8 UN Technical Guidelines core CSE concepts. The educators reported high confidence, with 81-92% of all participants feeling confident to implement these concepts (Appendix 5, Table 6e). The concepts of a) values, rights, culture and sexuality and b) gender had the lowest scores.

In the post-workshop interviews the participants emphasised their confidence to implement the BtS methods in particular the disability sensitive teaching methods as well as most topics. The schools started to prepare for implementation through preparing school engagements (with staff and parents) and implementation guidelines and lesson plans.

> *In two weeks time, we thinking of starting the group work and introducing to learners in grade 4 and 5*
>
> *Workshop participant post intervention interview*

The topic of masturbation and sexual functioning were highlighted as the most difficult to implement. One participant stated: 'where do I even start to talk about masturbation, I do not feel comfortable'. This was despite the acknowledgement that their schools need to address this behaviour as already happening "Currently they [the learners] masturbate anywhere because there is no private place that they masturbate at, even in class they, masturbate". Hence this participant did not feel as yet confident to address these topics and stated, "I am scared of these children; they laugh and make a joke out of this".

In a different interview a participant made the suggestion, that these topics could be provided by therapy staff to support teachers with very sensitive material.

Enablers and Barriers

Firstly, participants emphasized that the staffs' understanding of the reality and vulnerability of learners with disabilities is one of the most important enablers. They highlighted that it is important for school management to understand this as well because they lead the school and their support is crucial for implementation.

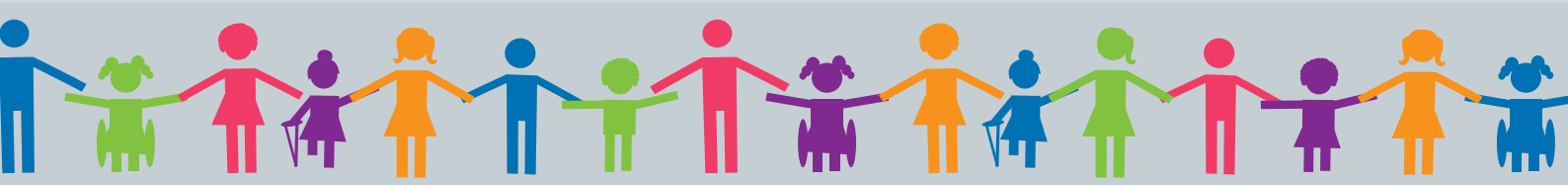
> *In understanding how vulnerable these learners are to all abuses, one immediately will understand the importance of implementing BtS*
>
> *Workshop participant post intervention interview*

Secondly, the ability to adjust teaching material to the learners' needs, build vocabulary and be able to demonstrate concrete concepts using a variety of sensory channels was seen as an important enabler to implement CSE with learners with disabilities.

> *It is important to demonstrate as well because they get to see it, feel it, imagine it because it not abstract. It makes more sense to them*
>
> *Workshop participant post intervention interview*

Lastly, it was seen as important for all staff members to participate in a BtS workshop. According to the participant, attending and experiencing the workshop is vital for ensuring successful implementation. Hence all participants emphasised the need for a whole school approach, including management, house mothers, parents, drivers, cooks, therapists and social workers. Having a social worker at the school was seen as important, because the school would then have someone who has "full understanding" of the vulnerability of and high prevalence of violence amongst their learners. Participants said that CSE training needs to include hostel staff as most cases of abuse are reported from this context. Hence, participants revealed that all people in contact with learners need to be able to identify nonverbal cues and understand the learners better.

> *These learners do not know that for example when an uncle touches them inappropriately it is 'a no touch'. So the whole school does need Breaking the Silence*
>
> *Workshop participant post intervention interview*



Furthermore, space for CSE lessons and privacy were seen as important, and the opportunity to have a therapist at the school who could assist with more sensitive topics. Considering the lack of male staff at some special schools it was also suggested to include trained drivers (who are usually men) in some CSE lessons, in particular those that work around male sexual development and function. The ethical consideration of such an approach has to be discussed in each setting taking into account risks and benefits.

Cultural beliefs and practices were seen as one of the key barriers to implementation of CSE. Participants reflected particularly on anti-CSE propaganda, parents, and untrained staff members.

Firstly, participants reflected on a widespread resistance to CSE, which they had witnessed in public (such as taxis) and among their peer educators. This provided a conflict and constant challenge for them

> *Worldwide people are against CSE, even at the taxis passengers talk about CSE and are against it*
>
> *Workshop participant post intervention interview*

> *There was a lot of resistance towards attending the BtS workshop because of the influence of religion. They [staff members who did not participate] will say it's against their religion or culture to actually teach it*
>
> *Workshop participant post intervention interview*

Secondly, participants explained that parent 'by-in' could be influenced by cultural beliefs that shape sexuality as a taboo topic or simple disinterest in their children, hence parent meetings were seen as a solution.

> *Some of the parents may feel that the school is against religious beliefs or cultural beliefs*
>
> *Workshop participant post intervention interview*

> *Because when children are here at school, their parents do not visit them frequently. Even if we call them and inform them that their child is sick very few are quick to come into the issue at hand*
>
> *Workshop participant post intervention interview*

Some participants also believed that parents will support CSE because that meant 'they will not be the one to teach CSE to their children'.

> *In terms of them handling and talking about this topic at home, they not interested'*
>
> *Workshop participant post intervention interview*

In addition, participants revealed that parents of learners, who need alternative communication such as sign language struggle to communicate with their children and difficult topics such as sexual abuse are therefore easily dismissed or not understood.

Participants suggested that parent meetings are crucial and need to address the need for CSE and how knowledge about the body and rights can be empowering and protective of their children. Participants indicated that house mothers had a similar role to play to support implementation.

> *Allow parents to express their understating of CSE, then after they can be informed of what CSE is- knowledge is power*
>
> *Workshop participant post intervention interview*

> *A house mother then becomes a mother, outside the home setting. The same applies, the learner in this case will first go to their mother here at school. So these house mothers also need to be equipped with the knowledge and the skill to be able to identify change of behavior etc ….and know how to handle a learner when they report to them*
>
> *Workshop participant post intervention interview*

Lastly, educators, who did not attend the workshop were seen as a potential barrier if they held negative cultural beliefs about CSE. Participants suggested that through engaging with these educators and through inviting them to observe CSE lessons it might be possible to change their minds. The fact that a critical mass of staff members had been trained with the approach in both schools was seen as an important factor to drive this change.

> *Now we have a bigger number of educators who attended the workshop so this is allowing a 'louder voice' that could be a more convincing voice for encouragement*
>
> *Workshop participant post intervention interview*

In addition, their own confidence and practice in providing CSE lessons were identified as an important element to change implementation barriers.

> *People are usually not confident because they don't know so, they need to be well informed about these topics. Practice the lessons from the BtS study materials*
>
> *Workshop participant post intervention interview*

Furthermore, participants indicated that "BtS approach is a very good curriculum to follow at schools to eradicate the stigma that is associated with disability and CSE in general". The BtS approach was seen as a starting point for introducing CSE and understanding the steps needed to conduct these lessons. Participants stated that this method was something they "can confidently engage in and teach learners". It was highlighted that sometimes learners prefer communicating with therapists and nurses more than educators when it comes to personal issues and that this can be used as an additional method to overcome barriers.

Impact of COVID-19 on the usage of BtS Teaching Methods

The post-workshop survey also included questions on which BtS methods would need adaptations under COVID-19 regulations. This set of questions indicates mixed results ranging from educators feeling confident about implementing the methods without adaptations, while others think they need to be adapted under COVID conditions (Appendix 5, Table 6f). Hence, although the COVID-19 regulations relating to social distancing and hygiene impact how educators can implement some of the BtS methods (e.g. group work), the workshops were still able to safely illustrate the BtS approach.

In the post-workshop interviews participants explained that the COVID-19 lock down had a significant impact on the structuring of lessons, specifically lesson time. Unlike other schools which may have chosen online teaching or alternate days spent on the property, schools for learners with disabilities often don't have these options. Hence, they" had to begin lessons early in the morning and close school by 12:30pm every day". Learning has been negatively impacted because of lost time and rearrangement of classrooms, which does not allow learners to sit close together. Shorter lesson times meant that completing the curriculum has become challenging and this has come at the expense of CSE. Participants emphasized that learners with disabilities however require intensive, long and flexible learning time. To shorten the classes is to decrease the amount of time spent learning concepts.

> *We also want to implement this approach while we are still fresh, so if another lockdown would take place it will be very difficult*
>
> *Workshop participant post intervention interview*

> *COVID19 has impacted and will impact especially in this winter season because we will be getting the third wave and still some learners are not back at school, so we will keep repeating lessons again, this will be difficult for the educator because of our time dedicated for the syllabus*
>
> *Workshop participant post intervention interview*

> *COVID-19 is a pandemic on it's own, students will forget about the BtS approach because more worries will be directed to COVID*
>
> *Workshop participant post intervention interview*

On the contrary some participants also revealed that "COVID-19 could be helpful in a reverse way". They said that given the social distancing regulations COVID could be used to explore closeness, relationships, physical touch and even sexual activity.

> *COVID is a Gateway to explore and understand touch – why do people miss it, why do people want to go and hug friends, why do people need touch and how does it feel to be embraced, … the learners are searching for closeness with people because they have lost their significant people. Hence, automatically the concept of relationships is brought up*
>
> *Workshop participant post intervention interview*

COVID has been used to educate learners on personal space; "always have to be 1.5m from somebody so that you feel safe. They don't come into your space." (workshop participant post intervention interview).

> *COVID-19 could be used as a vehicle for educating learners about hygiene, and safe health sexual behavior. The fact that you must wash your hands. With sexual education you also need to wash your hands, …your hands are clean before engaging in sexual activity with yourself [e.g. masturbation] or with another person. This is followed by keeping clean, and germs, same like you get germs on your hands, you can get germs on your penis*
>
> *Workshop participant post intervention interview*

The participant further stated that COVID-19 lockdown has contributed greatly to the sexual abuse cases on learners at the school. Participants noticed that after a school holiday or quarantine there are changes in learners' behaviors 'some pee on themselves because they fail to hold their urine, you just see that they have been sexually abused'. Hence addressing sexual abuse and violence was seen as exacerbated post school breaks and lockdowns.

Limitations of TSE-Q results

This feasibility study only included 26 educators from 2 pre-selected schools in the pre- and post-workshop survey. Hence, the sample is small and not representative. In addition, the TSE-Q underwent its last stage of development and adaptation in this study (see next chapter). The data presented here can therefore only be seen as suggestive and is not representative. In order to evaluate the impact of the BtS approach on teaching and linkage to care, a complete evaluation study of the approach is needed.

Post-workshop participant feedback (rapid workshop evaluation)

During the BtS workshop, educators engaged with the BtS approach and teaching materials. The BtS methods and materials encourage educators to use locally available material. In addition, the workshop provides them with information on how to develop materials for their learners through directly engaging with sample material and their adaptations for different disability types and context.

After the workshops, a short evaluation form provided some feedback about the experience and impact of the BtS workshops. This evaluation included 26 educators and three official representatives (observers) from the DBE and disability sector (table 7). The results suggest that participants enjoyed the workshops and gained skills and knowledge to implement CSE. Educators described the workshops as: "very structured and informative", "clearly presented", "rich in content… and sensitive towards specific needs of deaf learners", "a life-changing course", "fun, friendly with no cultural barriers", "enjoyable and informative" and "empowering".

Table 7 Participant Workshop Feedback

Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
1. The objectives of the workshop met my training needs				
20	**7**	**2**		
2. The workshop content was relevant to my work				
21	**5**	**3**		
3. The workshop improved my understanding of the subject matter				
22	**7**			
4. The workshop provided new knowledge and practical skills ideas for improving my professional work				
24	**1**	**4**		

Educators also reflected on their internal change during the workshop, indicating a change in attitude and skills.

> *"Thank you so much for an interesting course, I was a bit sceptical in the beginning, but it really equipped me as an educator on rethinking my world, reflecting on my values, and accepting other people's opinions"*

"It [the workshop] made me think of the way I plan for my lessons taking into consideration what knowledge, skills, values, and attitudes I teach."

"It [the workshop] is an eye-opener, and I can be more comfortable now that I have this knowledge."

In one setting, several educators spoke about feeling reluctant to attend the workshop based on their misperceptions about CSE (possibly reflecting current anti-CSE campaigns on social media).[62] Yet the feedback, both written and spoken from those who attended showed an attitude shift toward CSE as being necessary and supportive to their learners wellbeing. During the workshop, some of the educators initially expressed ambivalence about using the names of private body part words, and yet by the second day they participated fully in activities to name private body parts and learn about sexual development.

This illustrates that attitudes and behaviour can change within a supportive and reflective space. Furthermore, participants reflected on the need for more workshops and additional engagement time. They requested additional workshops in their organisations/schools, insisting on participation from management and reaching out to parents and GBV care centres such as the Thuthuzela centres.

"I need all of you, come to [name] to have a workshop with staff." (workshop participant)

"The workshop should be recurrent. Please insist on managers attending the workshop." (workshop participant)

"Also insist on more hostel staff attending" (workshop participant)

"I do feel that all principals and all teachers would benefit from this training and even parents could benefit." (workshop participant)

"Thuthuzela centre must have physio doctors and doctors who knows about our learners." (workshop participant)

The feedback also included information on key takeaway ideas, implementation strategies, and further needs or improvements.

Key take away Ideas Participants got from the Workshop

When asked to reflect on the key ideas that they would take away and implement from the workshop many of participants commented on the interactive teaching tools, using group work and activities to make learning enjoyable, as well as the need to break concepts down into small steps. After the workshop's participants stated that they learnt:

- How to make or teach CSE in a simple language through group activities. (participant workshop evaluation)
- How to deliver the lesson to the learners using stories and pictures. (participant workshop evaluation)
- Knowledge, skills, values, and attitudes. How to implement/how to present using concrete to abstract. (participant workshop evaluation)

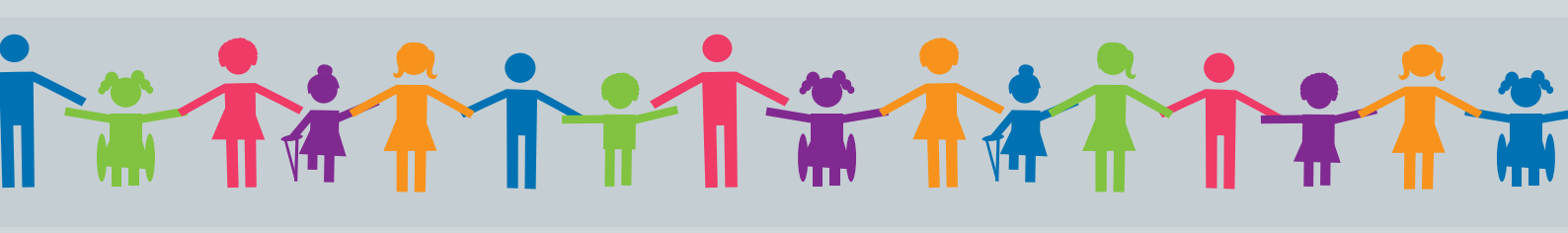
Participants reflected on provided example materials that they could use in their schools/organisations such as picture material, games, storytelling, role-play, participatory activities. After the workshops they revealed that they would:

- Impart decision-making skills through using creative games. (participant workshop evaluation)
- Use the tools to practically use in class, language learners in a fun way. (participant workshop evaluation)

They also reflected on concepts and vocabulary building that they felt they needed to improve in their lessons using the BtS resources to improve vocabulary around "emotions, assertiveness, relationship types, decision making, and saying yes and no, human developmental stages, and HIV and other diseases." (workshop participant).

Participants also identified the key idea to be more explicit with learners with disabilities in teaching about sexuality as well as the learners right to accurate information. At the end of the workshop, they revealed that they needed:

- To be explicit in knowledge. (participant workshop evaluation)
- To teach as explicitly as possible not leaving any questions in learners' minds. (participant workshop evaluation)
- To make sure they get the facts… [because] our children are getting information from all over about sex and sexuality (participant workshop evaluation)



Trialling BtS with learners with hearing impairment and the Deaf

In this feasibility study the BtS approach has been trialed with educators and community workers working with learners who are hearing impaired or the Deaf. One educator commented that it was the first time that they had received training that catered for their needs:

> *I feel, really for the first time I am attending a course where it's really customized to our needs as a school for hearing impaired and deaf children. We are so exposed to courses and conferences where mainstream is the focus, and we are left to try and adapt the content to our needs, and it is really very difficult.*
>
> *Workshop participant*

It was evident that the use of visual resources, pictures, signs and symbols was essential to building and developing learner vocabulary both signed and read. This applied to the particular learning needs of learners with hearing impaired and the Deaf as shown by the educator comment below.

"This course is fundamental for these children very important because these children being hearing impaired, they don't have a lot of vocabulary and so expressing themselves is not easy. They are also often in the minority in their community and so they are ignored and isolated they lack a lot of information and they are not gathering information from conversations around them, they need information directed toward them by a teacher or facilitator or a counsellor. So this is where this course is extremely important, because it hones in on exactly the kind of vocabulary these children need around their sense of themselves, their body, their relationships with people their sexuality." (workshop participant).

The need to build vocabulary for hearing impaired learners or the Deaf was strongly emphasized in the educators' expectations. One principle of social learning theory is that if modeled behaviour is coded into words, labels or images then there is better learning retention than through simply observing.[64] The BtS approach of using signs, symbols, pictures to support key learning concepts strengthens the learning process for all learners, but is particularly relevant both to learners with intellectual disability and learners with hearing impairment or the Deaf.

Views on Implementing the BtS Approach

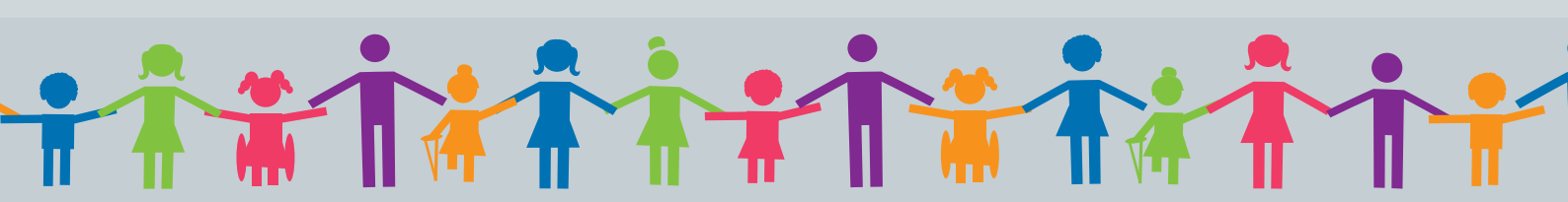
Participants also shared their views on how they could implement the BtS methods. They suggested that implementation could take place in their classroom settings, during group work or counselling sessions. The development of school implementation guidelines for CSE was mentioned as an essential enabler of implementation by some participants.

> *After communicating with the school management and guidelines are made, I will incorporate CSE in our weekly themes such as healthy living, safety, etc.*
>
> *Workshop participant*

Furthermore, involving all "colleagues, parents, the SGB and school stakeholders" was seen as essential to implementing CSE. In fact, "relating relevant aspects to the teachers who didn't attend" or "to develop other staff members" was identified by several participants as necessary. The motivation to share their learning was significant considering the resistance several participants had felt before attending the workshop as well as the possibility that absent staff had not attended due to their misperceptions about CSE.

In addition, the involvement of students in their lessons and activities was identified as an essential enabler. Hence, participants reflected that it was necessary to: "be more practical with students … let students be more involved in lessons…and engage and allow learners to participate." (workshop participants). These comments show an understanding of CSE as a rights-based and child-centered approach that goes beyond simply providing information. After the workshop's participants emphasised that:

- Children have a choice/ It's ok to say no. (participant workshop evaluation)
- It is important to be patient when the children talk to you. (participant workshop evaluation)
- They have learnt how to empower learners with their rights, to teach them about developmental changes and to educate them about different sexually transmitted diseases. (participant workshop evaluation)



Suggestions for Improvement of further Needs

Some participants reflected that they would like to have more time and space to explore the BtS methods and develop their own materials. Some participants also requested more time on particular topics such as sexual identity and gender, sexuality and the law, different age groups, making teaching tools, positive media coverage of CSE, and audio-visual material. It was evident, that educators are not familiar with participatory learning methods so essential to CSE, and many have to unlearn a familiar way of delivering content. The time given to this process orientated aspect of the workshop is essential as shown by the participants intentions to replicate an active learning methodology with their learners as described above. It was also noticeable that much of the information on sexual development and sexual body function was new to the participants and time was needed to answer the participants questions and fill in gaps in their knowledge rather than focusing solely on the teaching tools.

A consequence of BtS (shown in this evaluation) is that educators are motivated to speak with their learners about their rights and bodies. This means that BtS will literally 'break the silence' and increase learner disclosure and or educator awareness of abuse. Participants during and after the workshop reported on their high load of sexual abuse cases and the need for support to manage these cases. Training and support on existing government processes were requested (for instance, form 22, which is used to report violence or abuse of learners from South African schools).

> *"The importance of filling form 22 [form to report violence] was imperative."*
>
> *Workshop participant*

> *"The different South African policies, department policies and Acts could be included as to be used as referral - eg of form 22"*
>
> *Workshop participant*

> *"The different South African policies, department policies and Acts could be included as to be used as referral - eg of form 22."*
>
> *Workshop participant*

This indicates a high need of learners in training of government/department policies and procedures, that might go beyond the available time and purpose of the BtS workshops. The link between BtS and increased reporting means that schools undertaking the programme need to strengthen their reporting and referral systems as well as consider how to better support educators responding to the disclosure of learner abuse. Hence this needs to be supported with ongoing training and support at each school.

TSE-Q Validation

Objective 4 tested the reliability and validity of the TSE-Q using baseline data. The Cronbach alphas for the TSE-Q scales are listed in table 8. Except for the CSE knowledge and beliefs questions, all scales of the TSE-Q were within the acceptable range, indicating that the scales measured concepts with acceptable or relatively high internal consistency across all questions (table 8). However, the self-designed scales of 'disability and sexuality beliefs' and 'HIV-risk believes' had to be adjusted by taking out some items that did not support internal consistency. The CSE concepts did not reach the needed reliability for a scale and therefore has to be seen as a set of questions. In addition, our post-survey engagement with the participating educators revealed that two questions were misleading because they were negatively worded and required participants to disagree (double negative). This issue affects the questions: a) In my country I am not allowed to explain sexual intercourse to learners, and b) In my country I am not allowed to show a vagina diagram for teaching purposes (both allowed in South African CSE lessons). Hence, these questions may need to be formulated positively (with "agree" as the correct answer). Educators also indicated that they did not have enough knowledge about CSE policy.

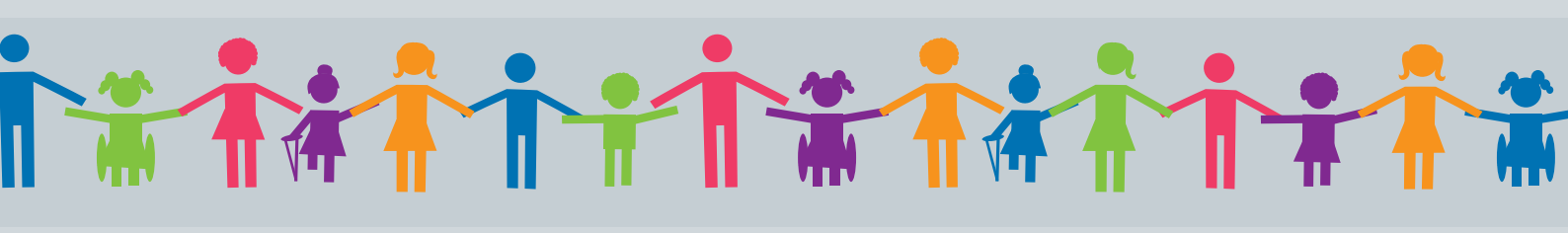


Table 8 Reliability Test TSE-Q

Concept	Scale (set of questions)	Cronbach's alpha	Adjusted alpha*
CSE policy knowledge	Prompting knowledge about CSE policy in this country	0.23	0.60
CSE beliefs	Prompting beliefs about impact and purpose of CSE	0.57	
Disability and sexuality beliefs	Prompting beliefs about disability and sexuality	0.61	0.68
HIV risk beliefs	Prompting beliefs about HIV risk of learners	0.56	0.74
Teaching beliefs	Prompting if educators should teach about:		
	The Body and Human Development	0.92	
	Different types of relationships in society	0.87	
	Personal skills needed for sexual decision making	0.96	
	Different types of sexual behaviour	0.91	
	Sexual health, including contraceptives, abortions, STIs and abuse	0.89	
Teaching practices	Prompting if educators teach about:		
	The Body and Human Development	0.91	
	Different types of relationships in society	0.92	
	Personal skills needed for sexual decision making	0.95	
	Different types of sexual behaviour	0.88	
	Sexual health, including contraceptives, abortions, STIs and abuse	0.92	
Normative beliefs about teaching CSE	Prompting who expects educators to deliver CSE	0.81	
Self-efficacy	Prompting self-confidence to deliver CSE to learners with disabilities	0.95	
Materials and preparation	Prompting preparation to deliver CSE to learners with disabilities in terms of training and available materials	0.84	
*Adjusted alpha after removing problematic items			

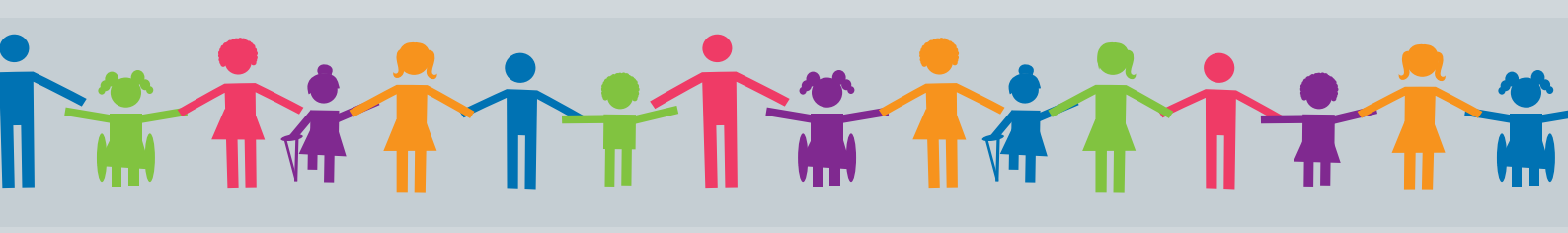
We also asked participants to validate the TSE-Q (table 9). Initially, we had planned to provide the TSE-Q as an electronic survey that could be completed from a cell phone. Unfortunately, against our expectations, educators at the two schools had no access to the internet at the time. We thus had to use the backup paper version. Unfortunately, this version included one scale twice and some minor formatting errors.

The validation results show that the TSE-Q is clear in terms of the question formulation (face validity). However, the provided form had some repetition and formatting errors. In addition, half of the participants also felt that there should be additional questions included (but didn't provide examples). Therefore, we removed the repetitive questions and addressed the formatting errors in the paper version.

Lastly, educators felt that the questionnaire helped capture educators' experience with CSE. However, they also shared that they found the content uncomfortable. They also felt that the questionnaire took a lot of effort and time to complete. Hence, this questionnaire should be used when educators have time and should not be squeezed in before or at the end of a workshop or school day. In addition, not all scales have to be used all the time. For instance, if self-confidence is already very high as in our baseline survey one does not need to ask these questions again. Similarly, the questions around professional preparedness might not need to be asked again in the post workshop survey, while the questions on implementation of BtS only apply to the post workshop survey.

Table 9 Face, Content Validity and Easy of Usage TSE-Q

		Disagree	Neutral	Agree
Face validity	I was able to answer all of the questions.	7	3	40
		14%	6%	80%
	The instructions were clear and easy to understand.	9	3	38
		18%	6%	76%
	The questions were clear and easy to understand.	12	3	35
		24%	6%	70%
	The overall questionnaire makes sense.	5	5	40
		10%	10%	80%
	The response categories for the questions were adequate.	14	6	30
		28%	12%	60%
Content validity	The questionnaire was designed to capture the knowledge and experiences of educators in teaching sexuality and HIV to learners with disabilities. The questionnaire captured these elements:	3	6	41
		6%	12%	82%
	The instrument included important items that describe how I view teaching sexuality and HIV to people with a disability.	4	3	43
		8%	6%	86%
	The instrument included items that were repetitive or redundant.	22	2	26
		44%	4%	52%
	There were items missing in this questionnaire that should be included.	29	5	16
		58%	10%	32%
	Some of the questions seemed out of order.	37	3	10
		74%	6%	20%
	I was able to find my answer in the list of possible answers to the questions.	10	8	32
		20%	16%	64%
Ease of use	I felt uncomfortable answering some of the questions because I did not want anyone to know my answer.	33	6	11
		66%	12%	22%
	The questions made me think about things that I would have preferred not to have thought about.	22	6	22
		44%	12%	44%
	Answering the questions helped me in some way.	7	3	40
		14%	6%	80%
	The questionnaire took too long to complete.	17	9	24
		34%	18%	48%
	The questionnaire required too much effort to complete.	25	3	22
		50%	6%	44%
	This questionnaire is useful in describing the experience of teaching sexuality and HIV to learners with a disability.	5	3	42
		10%	6%	84%



Recommendations

This study aimed to understand the feasibility (practicability of implementing the BtS training) and identifying barriers and facilitators of implementing the BtS approach to CSE during the COVID-19 epidemic in two South African special schools.

Objective 1:

The data reveals that the two participating schools had few supporting structures available to implement CSE with their learners. The lack of detail or practical guidance within the current Life skills and Life Orientation Curriculum alongside a lack of departmental CSE training means educators lack the skills to deliver sexuality education. Educators lacked knowledge about CSE content, policy and implementation methods especially in relation to the learning and sexual health support needs of learners with disabilities. There was also a lack of internal guidelines on implementing CSE safely and support for managing cases of sexual abuse. Hence, interventions that target increased access to CSE in schools that cater for learners with disabilities should conduct a school needs assessment before any intervention. Schools should also be supported in developing internal guidelines and structures for CSE implementation linked to SRH care and reporting of sexual violence. These are elements that were promised in South Africa's White Paper six and its inclusive education policy.[65] Our findings indicate that this support and training for educators is currently not happening as yet for the context of providing Life skills and CSE to learners with disabilities and calls for training and support of schools who cater for learners with disabilities.

Objective 2:

Some educators held misconceptions about CSE, disability and sexuality, yet are aware of their learner's HIV risk and duty to teach CSE. For example, many educators agreed that they should teach CSE topics before the BtS workshops. However, they were only implementing soft topics around values and relationships, if at all. Cultural values, taboos, and misconceptions about disability and sexuality dictate what educators feel they can implement. The attitudinal shifts in participants after experiencing the BtS workshops shows it is possible to facilitate attitudinal change within the workshop and a relatively short space of time. Hence, it is essential to give time and a collective space in the training to examine and explore these individual values and norms before developing CSE delivery skills. Current misperceptions and negative attitudes toward CSE highlight the need for strong leadership and positive messaging on CSE.

Objective 3:

It is possible to implement BtS training in three days. However, many educators indicated the need for more continued training and access to information, which potentially could be provided through additional online learning. Some prior learning (face to face or online) with regards to basic CSE information concerning sexual development could be provided before the workshop so that sexual development and sexual health training components in the workshop can focus on adaptions for learners with disabilities especially considering the increased need for explicit and concrete information. Additionally, the process and practical orientated aspect of the workshop is essential to an active learning methodology and there needs to be adequate time to plan, experience and reflect on activities and facilitation skills. They also emphasise the importance of a whole-school approach to ensure that all staff members are on board. Nevertheless, our study also shows that only a portion of educators/staff can be trained at one time (because of time, beliefs, and value issues) and that potentially 2 or 3 workshop dates need to be provided to enable all educators to take part. Furthermore, a whole-school approach is essential as educators are exposed to anti-CSE propaganda and may hold misconceptions about the purpose and impact of CSE. Buy-in and support from school management are crucial to motivate hesitant staff. However, school management might struggle to free themselves to participate in a three-day workshop. A four-hour brief meeting for managers was suggested as an alternative. In addition, getting staff buy-in might need creative ideas. For example, linking a school or organisation to a local Disabled Peoples Organisation (who often support access to CSE and SRHR) and an introductory meeting before CSE workshops could increase support for CSE among staff and community members. In addition, many participants highlighted the need for ongoing training, and this could potentially be picked up with online training support.

COVID-19 regulations on social distancing and requirements for disease control can also impact CSE implementation. Workshop facilitators need to show how methods can be adapted to work within these restrictions. At the same time, educators need to balance the need for infectious disease prevention and providing opportunities for social learning and experimentation with CSE material (feel, smell, touch, hear, and see). In addition, participants revealed how COVID social distancing and hygiene regulations can actually be used to reemphasise topics related to CSE.

Lastly, when breaking the silence with the BtS approach, it is crucial to plan for the increased discussion and reporting of abuse. Both workshops showed that sexual abuse is a common experience, and educators need to be equipped and supported to deal with it. Therefore, CSE workshops elsewhere need to support educators/staff in this work through clarifying pathways of reporting and handling of sexual violence and abuse, offering to counsel educators, and supporting the school to develop CSE school implementation guidelines that aid reporting of sexual violence in addition to the support and guidance from the Department of Education. These schools need internal CSE implementation guidelines to ensure that CSE can be implemented and additional support outside the BtS workshops. The BtS situation analysis presented in this report and the model CSE guidelines included in the BtS comprehensive guide can support this work. In addition, the Department of Education needs to facilitate ongoing training and support for cases of sexual violence and the reporting procedures related to it.

Objective 4

The BtS research tools TSE-Q was validated during this study. The validation of the questionnaire revealed acceptable internal consistency for most of the scales/ set of questions, identified needed changes in terms of repetition and formatting, and the need to adapt the language in the CSE knowledge set of questions. The validation also revealed that time and an appropriate place is needed to complete the TSE-Q.

As such, the TSE-Q can be used as a tool to evaluate the impact of BtS or other CSE approaches for educators of learners with disabilities. Indeed, as a next step, a complete evaluation of the BtS approach with a representative sample should be undertaken. In such a study, researchers need to consider that they:

1) need to account for those who will not take part in CSE workshops because of CSE stigma and lack of time by doubling the sample size;
2) need to use the TSE-Q when educators have time and can concentrate as the tool includes many scales, and
3) conduct a situation analysis to understand the broader context of the school and potential barriers that can impact CSE training. Future BtS workshops also need to continue to emphasise the need for a whole-school approach, including participation from management and the development of internal school implementation guidelines for CSE.

Appendices

Appendix 1 Theory of Change

Problem: Young people with disabilities are more vulnerable to adverse SRH outcomes and not enjoying access to their SRHR on an equal basis with others

Problem: Young people with disabilities are more vulnerable to adverse SRH outcomes and not enjoying access to their SRHR on an equal basis with others

Misconception about disability and sexuality	Lack of SRHR knowledge and access to CSE for young persons with disability	Lack of teachers and parents' skill to provide CSE	Lack of reporting of violence and conviction of perpetrators	Poverty among young people with disabilities and their households

What types of interventions are needed to address these risk factors

Interventions that address community norms and values	Interventions that addresses lack of knowledge and skills (particularly in regards to sexuality and comprehensive sexuality education)	Interventions that improve access to justice	Interventions that address the cycle of poverty and disability

What specific aspect of the intervention (or input) will be included?
School based intervention with community reach out and peer support

Disability and SRHR sensitization. in the community	Comprehensive Sexuality Education in accessible formats	Training of Educators to provide CSE in accessible formats	Strengthening linkages between Schools, DPOs , NGOs and police	Identify economic opportunities for persons with disabilities/ parents

What will be the initial outputs?

Parent-teacher support and reach out groups established	Children/adolescents accessing CSE	Teachers trained with "Breaking the Silence" approach	School community support networks established	Policy change for economic uplifting of persons with disabilities/ families

What is the envisioned medium term outcome?

Less people hold misconceptions, services are accessible to more people stop sexual violence	Young people with disabilities and their carers are aware of the right to access SRH and report violence	Educator's provide accessible CSE to learners with disabilities and parents talk about sexuality	More perpetrators are convicted and community supports victims	Good practice examples guides economic uplifting of families with young people with disabilities

What is the long-term outcome?
Increased access to CSE and SRHR services and less violence against young people with disabilities

Appendices

Appendix 2 Adapted Version of Validity Questionnaire Rowe, Oxman and O'Brien

You have previously completed the Teachers Sexuality Education Questionnaire (TSE-Q). The goal of the questionnaire is to describe the knowledge, confidence, attitude, normative beliefs and practice of educators teaching sexuality education to learners with disabilities. We would like to get your feedback on its use. Please circle the most appropriate numeric answer on the scale in response to each of the following statements (applicable to the TSE-Q).

Face Validity

1. I was able to answer all of the questions.

Highly disagree | Disagree | Agree | Highly Agree

2. The instructions were clear and easy to understand.

Highly disagree | Disagree | Agree | Highly Agree

3. The questions were clear and easy to understand.

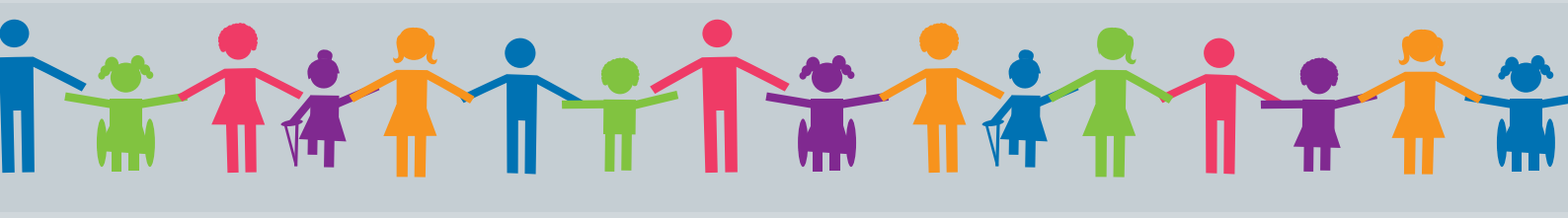
Highly disagree | Disagree | Agree | Highly Agree

4. The overall questionnaire makes sense.

Highly disagree | Disagree | Agree | Highly Agree

5. The response categories for the questions were adequate.

Highly disagree | Disagree | Agree | Highly Agree



Appendices

Appendix 2 Adapted Version of Validity Questionnaire Rowe, Oxman and O'Brien (continues)

Content Validity

6. The questionnaire was designed to capture the knowledge and experiences of educators in teaching sexuality and HIV to learners with disabilities. The questionnaire captured these elements:

Highly disagree | Disagree | Agree | Highly Agree

7. The instrument included important items that describe how I view teaching sexuality and HIV to people with a disability.

Highly disagree | Disagree | Agree | Highly Agree

8. The instrument included items that were repetitive or redundant.*

Highly disagree | Disagree | Agree | Highly Agree

9. There were items missing in this questionnaire that should be included.*

Highly disagree | Disagree | Agree | Highly Agree

10. Some of the questions seemed out of order.*

Highly disagree | Disagree | Agree | Highly Agree

11. I was able to find my answer in the list of possible answers to the questions.

Highly disagree | Disagree | Agree | Highly Agree

Appendices

Appendix 2 Adapted Version of Validity Questionnaire Rowe, Oxman and O'Brien (continues)

Ease of Usage

12. I felt uncomfortable answering some of the questions because I did not want anyone to know my answer.*

Highly disagree | Disagree | Agree | Highly Agree

13. The questions made me think about things that I would have preferred not to have thought about.*

Highly disagree | Disagree | Agree | Highly Agree

14. Answering the questions helped me in some way.

Highly disagree | Disagree | Agree | Highly Agree

15. The questionnaire took too long to complete.*

Highly disagree | Disagree | Agree | Highly Agree

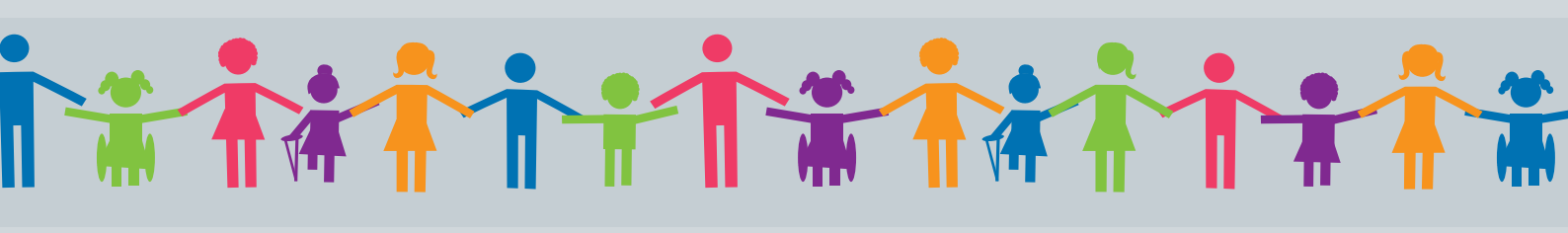
16. The questionnaire required too much effort to complete.*

Highly disagree | Disagree | Agree | Highly Agree

17. This questionnaire is useful in describing the experience of teaching sexuality and HIV to learners with a disability.

Highly disagree | Disagree | Agree | Highly Agree

*items reversed scored.



Appendices

Appendix 3 Short Post-Workshop Evaluation Questionnaire

INSTRUCTIONS: Please complete this form to help the workshop facilitators ensure that the workshop adequately meets your training needs.

Participant identifier: _____
Gender: _____
Date of birth: _____
Name of employer: _____

Please rate the following statements on a scale from 1 to 5 with

1 = ☺ strongly agree and **5 = ☹ strongly disagree**

1. The objectives of the workshop met my training needs

1	2	3	4	5

2. The workshop content was relevant to my work

1	2	3	4	5

3. The workshop improved my understanding of the subject matter

1	2	3	4	5

4. The workshop provided new knowledge and practical skills ideas for improving my professional work

1	2	3	4	5

5. What are the key ideas that you have taken away from the workshop?

_____
_____
_____

6. Which ideas do you think you will be able to implement or use?

_____
_____
_____

7. How do you intend to use these ideas at your school?

_____
_____
_____

8. How do you think we could improve the workshop?

_____
_____
_____

9. What things need to be added or changed to the workshop material or manual?

_____
_____
_____

10. What else do you like to tell us?

_____
_____
_____

Thank you so much for your time, support and input.

Appendices

Appendix 4 Baseline Survey Data Tables

Table 5a Participant Workshop Feedback

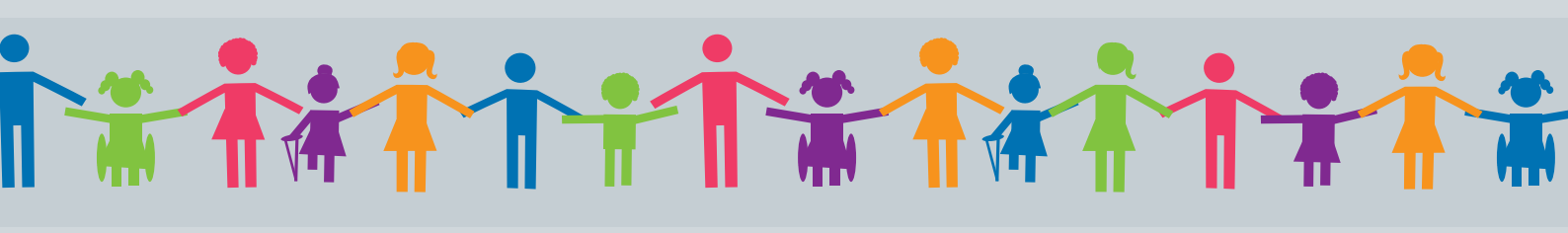
Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
1. The objectives of the workshop met my training needs				
20	**7**	**2**		
2. The workshop content was relevant to my work				
21	**5**	**3**		
3. The workshop improved my understanding of the subject matter				
22	**7**			
4. The workshop provided new knowledge and practical skills ideas for improving my professional work				
24	**1**	**4**		

Table 5b Baseline Survey CSE Knowledge

	Agree	Disagree	Don't know
Comprehensive sexuality education is standard policy for all learners in my country	25	5	20
	50	10	40
In my country, I am expected to teach learners about gender equity and equal relationships	39	4	7
	78	8	14
In my country, I am not allowed to explain sexual intercourse to learners	28	12	10
	56	24	20
In my country, I am not allowed to show a vagina diagram for teaching purposes	19	18	13
	38	36	26
In my country, I am allowed to inform learners correctly about sensitive topics such as homosexuality or masturbation	21	6	23
	42	12	46
In my country, I have to teach learners about their sexual and reproductive rights	37	3	10
	74	6	20
In my country, I have to teach learners how they can acquire HIV through sexual intercourse	45	1	4
	90	2	8

Table 5c Baseline Survey Believes about CSE

	Agree	Disagree	Don't know
CSE sexualises children and adolescents	19	15	16
	38%	30%	32%
CSE entices learner's sexual activity and risk-taking	18	14	18
	36%	28%	36%
CSE increases condom use and usage of contraceptive once needed	31	9	10
	62%	18%	20%



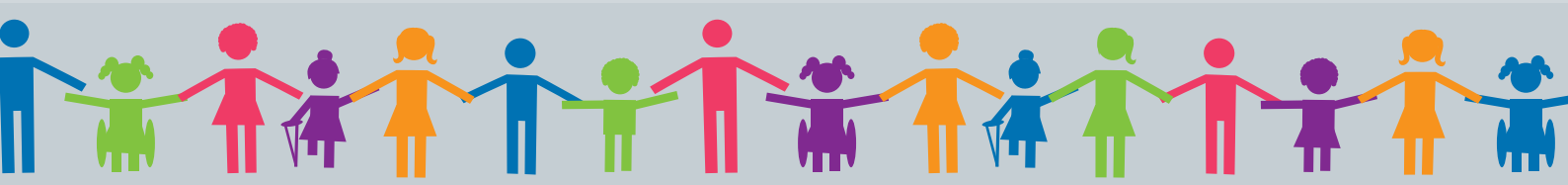
	Agree	Disagree	Don't know
CSE increases learners self-confidence and skills to report violence	41	2	7
	82%	4%	14%
CSE encourages learners to practice masturbation	13	17	20
	26%	34%	40%
CSE helps learners to tolerate different sexual orientations and gender identities	37	2	11
	74%	4%	22%

Table 5d Baseline Beliefs about Disability and Sexuality and Disability and HIV

	Agree	Disagree	Don't know
Our learners cannot understand information about sexuality	41	4	5
	82%	8%	10%
Our learners are hypersexual or oversexed	31	6	13
	62%	12%	26%
Our learners will not be capable of engaging in sexual activities in their lives	11	19	20
	22%	38%	40%
Our learners are not able to make sexual choices	26	13	11
	52%	26%	22%
Our learners cannot learn how to negotiate the use of condoms	26	11	13
	52%	22%	26%
Our learners are unlikely to form a family	18	16	16
	36%	32%	32%
Our learners are not sexually attractive	12	20	18
	24%	40%	36
Our learners are at risk of sexual abuse	40	5	5
	80%	10%	10%
Our learners know little about HIV and AIDS is:	34	8	8
	68%	16%	16%
Our learners do not believe that they can get an HIV infection	26	6	18
	52%	12%	36%
Our learners do not have enough HIV and AIDS information	33	7	10
	66%	14%	20%
Some of our older learners are exposed to unprotected sex	37	2	11
	74%	4%	22%
Some of our older learners have more than one sexual partners	22	2	26
	44%	4%	52%
Some of our older learners use drugs such as dagga and alcohol	19	3	28
	38%	6%	56%

Table 5e Baseline Participants Teaching Believes and Practice

		Should you teach?						Do you teach?		
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree		No	Sometimes	Yes
Human development	Reproductive anatomy	10	1	9	19	11		29	12	9
		20%	2%	18%	38%	22%		58%	24%	18%
	Reproduction	9	2	6	26	7		29	12	9
		18%	4%	12%	52%	14%		58%	24%	18%
	Puberty and adolescence	13	0	2	25	10		20	14	16
		26%	0%	4%	50%	20%		40%	28%	32%
	Body Image and changes	11	1	1	24	13		19	12	19
		22%	2%	2%	48%	26%		38%	24%	38%
	Sexual identify and orientation	8	1	8	21	12		27	13	10
		16%	2%	16%	42%	24%		54%	26%	20%
Relationships	Families	5	1	3	23	18		16	12	22
		10%	2%	6%	46%	36%		32%	24%	44%
	Friendship	7	1	3	17	22		19	8	23
		14%	2%	6%	34%	44%		38%	16%	46%
	Love	5	1	2	24	18		17	13	20
		10%	2%	4%	48%	36%		34%	26%	40%
	Dating	4	2	9	19	16		28	13	9
		8%	4%	18%	38%	32%		56%	26%	18%
	Marriage and commitments	6	3	10	15	16		26	12	12
		12%	6%	20%	30%	32%		52%	24%	24%
	Raising children	9	2	7	17	15		27	11	12
		18%	4%	14%	34%	30%		54%	22%	24%
Personal skills	Values	7	1	2	21	19		19	11	20
		14%	2%	4%	42%	38%		38%	22%	40%
	Decision-making	7	1	6	20	16		19	12	19
		14%	2%	12%	40%	32%		38%	24%	38%
	Communication	6	0	4	21	19		17	14	19
		12%	0%	8%	42%	38%		34%	28%	38%
	Assertiveness	6	1	8	23	12		20	17	13
		12%	2%	16%	46%	24%		40%	34%	26%
	Negotiations	5	2	5	25	13		22	15	13
		10%	4%	10%	50%	26%		44%	30%	26%
	Looking for help	7	0	2	20	21		15	11	24
		14%	0%	4%	40%	42%		30%	22%	48%



		Should you teach?						Do you teach?		
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree		No	Sometimes	Yes
Sexual behaviours	Sexuality through lifespan	5	3	7	24	11		31	11	8
		10%	6%	14%	48%	22%		62%	22%	16%
	Masturbation	4	11	8	18	9		37	10	3
		8%	22%	16%	36%	18%		74%	20%	6%
	Shared sexual behaviour (intercourse)	6	9	7	19	9		34	13	3
		12%	18%	14%	38%	18%		68%	26%	6%
	Abstinence	2	1	9	22	16		27	10	13
		4%	2%	18%	44%	32%		54%	20%	26%
	Human sexual response	5	4	9	26	6		33	11	6
		10%	8%	18%	52%	12%		66%	22%	12%
	Sexual fantasy	5	8	13	18	6		38	9	3
		10%	16%	26%	36%	12%		76%	18%	6%
	Sexual dysfunctions	5	6	12	20	7		38	10	2
		10%	12%	24%	40%	14%		76%	20%	4%
Sexual health	Contraceptives	2	4	5	24	15		27	15	8
		4%	8%	10%	48%	30%		54%	30%	16%
	Abortion	8	5	12	16	9		32	11	7
		16%	10%	24%	32%	18%		64%	22%	14%
	Sexual transmitted infections	3	4	3	24	16		25	11	14
		6%	8%	6%	48%	32%		50%	22%	28%
	Sexual abuse	2	3	2	20	23		24	9	17
		4%	6%	4%	40%	46%		48%	18%	34%
	Reproductive health	2	3	5	24	16		27	9	14
		4%	6%	10%	48%	32%		54%	18%	28%

Table 5f Baseline Participants Perceived Subjective Norms: Who expects you to deliver CSE?

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Learners	2	5	8	26	9
	4%	10%	16%	52%	18%
Governing body	1	6	14	23	6
	2%	12%	28%	46%	12%
Educators teaching the same subject	1	5	11	28	5
	2%	10%	22%	56%	10%
Educators teaching another subject	2	3	13	28	4
	4%	6%	26%	56%	8%
External school/ education experts	3	7	14	20	6
	6%	14%	28%	40%	12%

Table 5g Baseline Participants Self-efficacy and Confidence

Educator feels he/she can	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Participate in courses or read literature about developments in HIV education	1	5	5	30	9
	2%	10%	10%	60%	18%
Give a clear and open description of safe and unsafe sexual activities in the classroom	1	8	8	21	12
	2%	16%	16%	42%	24%
Formulate words for sexuality-related issues together with the learners by using a brainstorming session	1	8	8	23	10
	2%	16%	16%	46%	20%
Take care of learners with personal questions or problems regarding relationships and sexuality both in and out of class	1	3	11	23	12
	2%	6%	22%	46%	24%
Create a comfortable atmosphere to make learners feel safe to talk about relationships and sexuality	0	4	10	22	14
	0%	8%	20%	44%	28%
Recognize the influence of different morals and values on social processes to prevent discrimination (based on culture or sexuality) at all times	0	4	13	22	11
	0%	8%	26%	44%	22%
Commit learners not to talk about the personal experiences of their classmates outside the classroom	1	7	14	19	9
	2%	14%	28%	38%	18%
Facilitate discussion groups about HIV/AIDS such that they are not unacceptably disturbed by the attitudes or behaviour of one or two learners	1	5	12	22	10
	2%	10%	24%	44%	20%
Be able to guide a group discussion in such a manner that learners listen with respect to each others' opinions and ideas about relationships and sexuality	1	5	12	20	12
	2%	10%	24%	40%	24%
Stimulate learners to think of solutions to expected problems in negotiating with a partner about condom use by using a role-play	3	8	14	17	8
	6%	16%	28%	34%	16%
Lead a group discussion in a way that learners will share their views and opinions about relationships and sexuality by asking each other questions.	1	8	14	20	7
	2%	16%	28%	40%	14%
Give practical assignments (interviews, letters, video) to make learners acquainted with the diversity of sexual choices and dispositions (homo-/heterosexuality, mono-/ polygamy).	4	10	18	13	5
	8%	20%	36%	26%	10%
Conduct a role-play where learners practice how to tell a friend that they might be infected with an STD and that they should go to be tested.	3	7	11	22	7
	6%	14%	22%	44%	14%
Get learners to discuss in small groups possible solutions to expected problems in practising safe sexual behaviour.	2	7	13	21	7
	4%	14%	26%	42%	14%

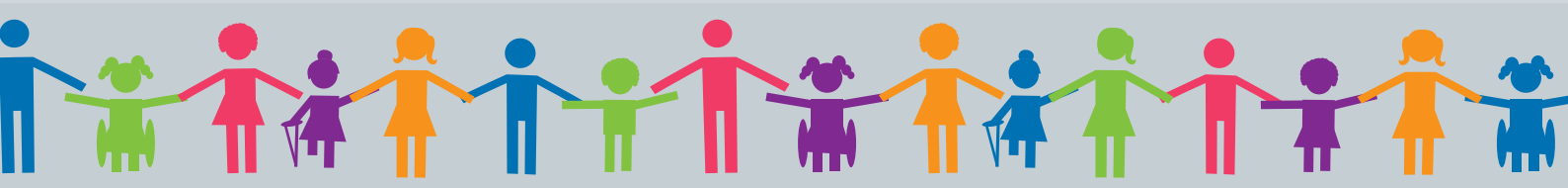


Table 5h Baseline Material and Professional Preparation

	No	Somewhat	Yes
There is sexuality and HIV education material available at my school	18	17	15
	36%	34%	30%
The sexuality and HIV education material is suitable for my learners' special needs	22	17	11
	44%	34%	22%
My colleagues and I have developed a customized approach and materials to teach sexuality and HIV education	27	11	12
	54%	22%	24%
I need (more) materials and tools that are suitable for the sexuality and HIV education of my learners	11	11	28
	22%	22%	56%
You make condoms available for your learners in the higher grades	28	6	16
	56%	12%	32%
My school offers HIV counselling that accommodates my learners' special needs	14	10	26
	28%	20%	52%
My school offers counselling services, including sexual abuse	11	8	31
	22%	16%	62%
I have ensured that I am included in mainstream HIV-awareness campaigns (e.g. Love life)	30	5	15
	60%	10%	30%
I have connected my counselling service to child protection services to address sexual abuse	26	5	19
	52%	10%	38%
I have developed an approach to involve parents and caretakers in the sexuality and HIV education of my learners	32	9	9
	64%	18%	18%

Appendices

Appendix 5 Post Workshop Data Tables

Table 6a Change in CSE Policy Knowledge

	Changed to Incorrect Answer	No Change	Changed to Correct Answer
Comprehensive sexuality education is standard policy for all learners in my country	8	9	9
	31%	35%	35%
In my country, I am expected to teach learners about gender equity and equal relationships	1	21	4
	4%	81%	15%
In my country, I am not allowed to explain sexual intercourse to learners	3	22	1
	12%[1]	85%	4%
In my country, I am not allowed to show a vagina diagram for teaching purposes	5	20	1
	19%[2]	77%	4%
In my country, I am allowed to inform learners correctly about sensitive topics such as homosexuality or masturbation	2	15	9
	8%	58%	35%
In my country, I have to teach learners about their sexual and reproductive rights	1	21	4
	4%	81%	15%
In my country, I have to teach learners how they can acquire HIV through sexual intercourse	2	23	1
	8%	88%	4%

Table 6b Change in CSE Believes

	Changed to Incorrect Answer	No Change	Changed to Correct Answer
CSE sexualizes children and adolescents	3	14	9
	12%	54%	35%
CSE entices learner's sexual activity and risk-taking	3	13	10
	12%	50%	38%
CSE increases condom use and usage of contraceptive once needed	5	17	4
	19%	65%	15%
CSE increases learner's self-confidence and skills to report violence	0	22	4
	0%	85%	15%
CSE encourages learners to practice masturbation	2	18	6
	8%	69%	23%
CSE helps learners to tolerate different sexual orientations and gender identities	0	21	5
	0%	81%	19%

1 This question was misleading and has been identified in the TSE-Q validation chapter as needing adaptation

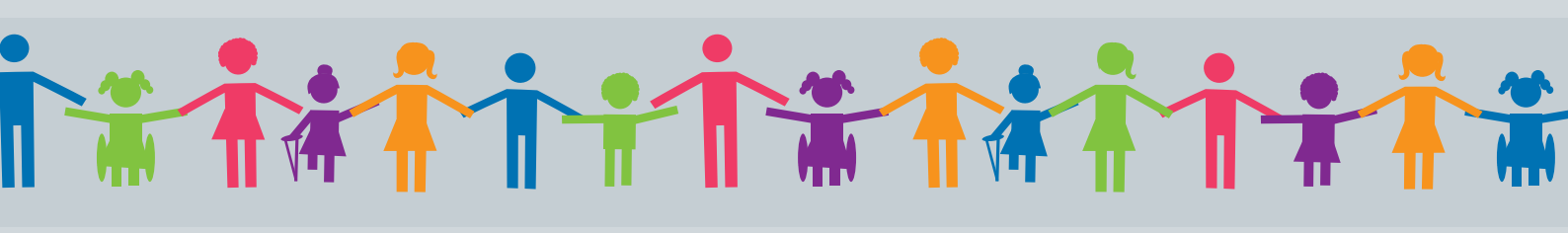
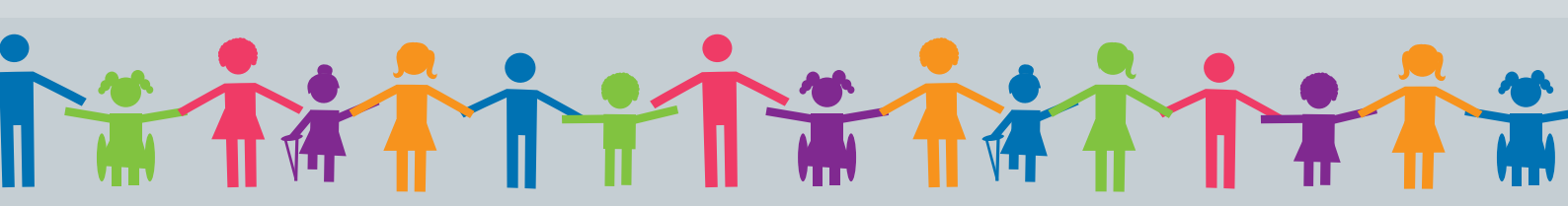


Table 6c Beliefs about Disability and Sexuality

	Changed to Incorrect Answer	No Change	Changed to Correct Answer
Disability and Sexuality Beliefs			
Our learners cannot understand information about sexuality	1	21	4
	4%	81%	15%
Our learners are hypersexual or oversexed	1	15	10
	4%	58%	38%
Our learners will not be capable of engaging in sexual activities in their lives	3	17	6
	12%	65%	23%
Our learners are not able to make sexual choices	4	17	5
	15%	65%	19%
Our learners cannot learn how to negotiate the use of condoms	2	18	6
	8%	69%	23%
Our learners are unlikely to form a family	0	18	8
	0%	69%	31%
Our learners are not sexually attractive	2	17	7
	8%	65%	27%
HIV Risk and Beliefs			
Our learners are at risk of sexual abuse	5	19	2
	19%	73%	8%
Our learners know little about HIV and AIDS	4	20	2
	15%	77%	8%
Our learners do not believe that they can get an HIV infection	1	20	5
	4%	77%	19%
Our learners do not have enough HIV and AIDS information	4	19	3
	15%	73%	12%
Some of our older learners are exposed to unprotected sex	4	19	3
	15%	73%	12%
Some of our older learners have more than one sexual partner's	1	21	4
	4%	81%	15%
Some of our older learners use drugs such as dagga and alcohol	5	18	3
	19%	69%	12%

Table 6d Teaching Beliefs

		More disagreement	Same as baseline	More agreement
Human development	Reproductive anatomy	5	9	12
		19%	35%	46%
	Reproduction	3	13	10
		12%	50%	38%
	Puberty and adolescence	3	14	9
		12%	54%	35%
	Body Image and changes	2	15	9
		8%	58%	35%
	Sexual identity and orientation	4	12	10
		15%	46%	38%
Relationships	Families	3	18	5
		12%	69%	19%
	Friendship	3	17	6
		12%	65%	23%
	Love	6	15	5
		23%	58%	19%
	Dating	4	13	9
		15%	50%	35%
	Marriage and commitments	7	11	8
		27%	42%	31%
	Raising children	8	11	7
		31%	42%	27%
Personal skills	Values	2	18	6
		8%	69%	23%
	Decision-making	2	16	8
		8%	62%	31%
	Communication	2	19	5
		8%	73%	19%
	Assertiveness	2	19	5
		8%	73%	19%
	Negotiations	2	17	7
		8%	65%	27%
	Looking for help	3	17	6
		12%	65%	23%



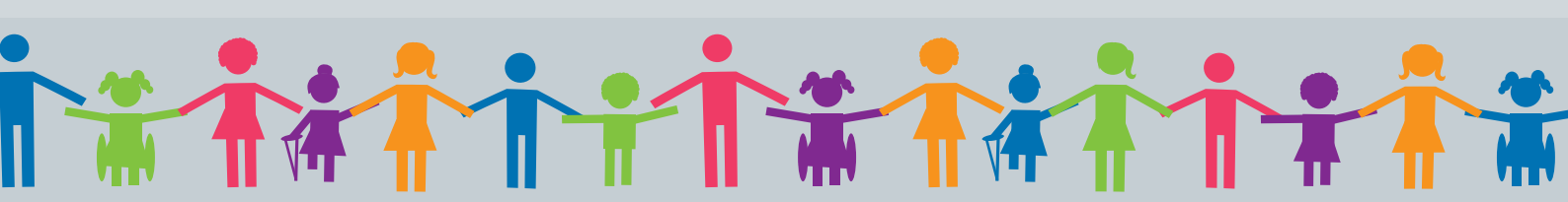
Sexual behaviours	Sexuality through lifespan	7	14	5
		27%	54%	19%
	Masturbation	4	14	8
		15%	54%	31%
	Shared sexual behaviour (intercourse)	5	14	7
		19%	54%	27%
	Abstinence	9	14	3
		35%	54%	12%
	Human sexual response	4	16	6
		15%	62%	23%
	Sexual fantasy	6	10	10
		23%	38%	38%
	Sexual dysfunctions	5	10	11
		19%	38%	42%
Sexual health	Contraceptives	6	16	4
		23%	62%	15%
	Abortion	7	11	8
		27%	42%	31%
	Sexually transmitted infections	4	19	3
		15%	73%	12%
	Sexual abuse	4	19	3
		15%	73%	12%
	Reproductive health	4	17	5
		15%	65%	19%

Table 6e Confidence to teach CSE Core Concepts during and after COVID-19

	Agree	Disagree	Don't Know
Relationships	21	2	0
	81%	8%	0%
Values, Rights, Culture and Sexuality	23	3	0
	88%	12%	0%
Gender	21	3	0
	81%	12%	0%
Violence and Staying Safe	24	1	0
	92%	4%	0%
Skills for Health and Wellbeing	24	0	0
	92%	0%	0%
Human Body and Development	21	1	0
	81%	4%	0%
Sexuality and Sexual Behaviour	21	1	0
	81%	4%	0%

Table 6f Impact of COVID 19 on the usage of BtS Teaching Methods

	Has to be adapted	More difficult to implement	No difficulty to implement
Conducting groupwork	10	11	5
	38%	42%	19%
Applying interactive games	10	10	6
	38%	38%	23%
Building vocabulary with oral object/body labelling and stories	7	6	13
	27%	23%	50%
Usage of visual and tactile tools	9	7	10
	35%	27%	38%
Handling material for comparison and categorisation	8	10	8
	31%	38%	31%
Telling/signing stories and character descriptions	10	6	10
	38%	23%	38%
Conducting role plays	7	9	10
	27%	35%	38%
Utilising peer education	9	7	10
	35%	27%	38%



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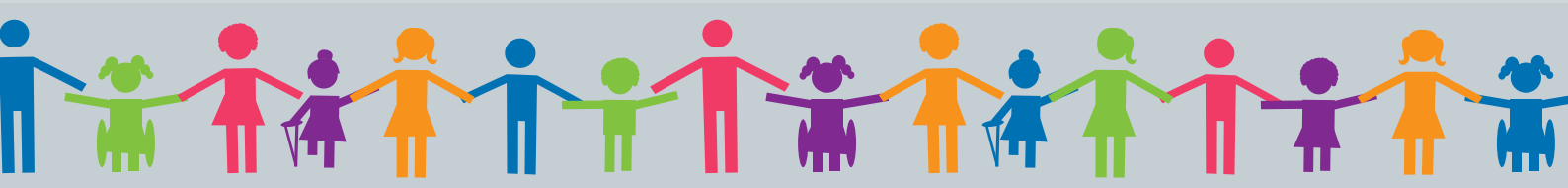

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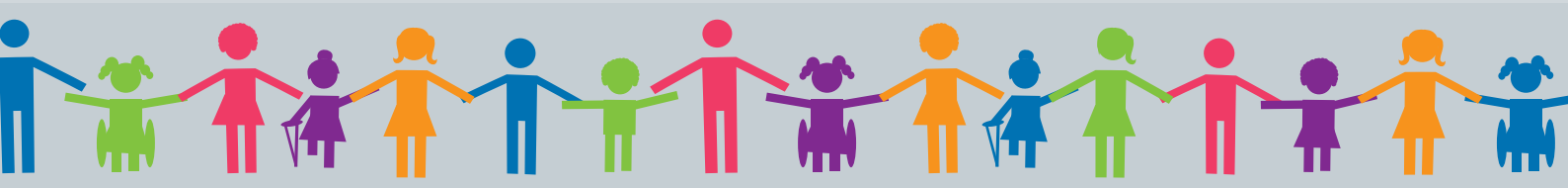

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