Skills and Technical Education Programme

United Nations Educational, Scientific and Cultural Organization

# STEP Research Series

## - No. 2 -

## SITUATIONAL ANALYSIS ON THE STATUS OF SEXUAL AND REPRODUCTIVE HEALTH OF STUDENTS AND GENDER-BASED VIOLENCE IN TECHNICAL AND VOCATIONAL COLLEGES IN MALAWI

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# Acronyms and abbreviations

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral therapy |
| ARVs | Antiretroviral drugs |
| BLM | Banja La Mtsogolo |
| CBDA | Community-based distribution agent |
| CBO | Community-based organization |
| CEDAW | Convention on the Elimination of All forms of Discrimination against Women |
| CSE | Comprehensive sexuality education |
| DHS | Demographic and Health Survey |
| ESCOM | Electricity Supply Commission of Malawi |
| EUP | Early and unintended pregnancies |
| FGD | Focus group discussion |
| FPAM | Family Planning Association of Malawi |
| GBV | Gender-based violence |
| HEARD | Health Economics and HIV and AIDS Research Division |
| HIV | Human Immunodeficiency Virus |
| HPV | Human papilloma virus |
| HTC | HIV testing and counselling |
| HTEI | Higher and tertiary education institutions |
| IEC | Information, education and communication |
| KII | Key informant interview |
| LSE | Life Skills Education |
| M&E | Monitoring and evaluation |
| MDHS | Malawi Development Health Survey |
| MoEST | Ministry of Education Science and Technology |
| MoGCDSW | Ministry of Gender, Children, Disability and Social Welfare |

| | |
|---|---|
| MoH | Ministry of Health |
| MoLYSMD | Ministry of Labour, Youth, Sports, and Manpower Development |
| MoU | Memorandum of understanding |
| NAC | National AIDS Commission |
| NCHE | National Council for Higher Education |
| NGO | Non-government organization |
| OSH | Occupational safety and health |
| PMTCT | Prevention of mother-to-child transmission of HIV |
| SADC | Southern African Development Community |
| SRH | Sexual and reproductive health |
| SRHR | Sexual and reproductive health and rights |
| STEP | Skills and Technical Education Programme |
| STI | Sexually transmitted infection |
| TEVET | Technical, Entrepreneurial and Vocational, Education Training |
| TEVETA | Technical, Entrepreneurial and Vocational Education Training Authority |
| TWG | Technical working group |
| TVC | Technical and vocational college |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UN WOMEN | United Nations Entity for Gender Equality and the Empowerment of Women |
| VMMC | Voluntary medical male circumcision |
| VSU | Victim support unit |
| WHO | World Health Organization |
| YFHS | Youth-friendly health services |

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## DISCLAIMER

# Executive summary

UNESCO commissioned a study to conduct a situational analysis on the status of sexual and reproductive health (SRH) of students and gender-based violence (GBV) in technical and vocational colleges (TVCs) in Malawi operating under the Technical, Entrepreneurship and Vocational (TEVET) system. The methodology comprised of a desk review, survey, key informant interviews, and focus group discussions. The sample for the situational analysis consisted of three technical colleges, namely Mzuzu Technical College in Mzuzu, Chongoni Community Technical College in Dedza, and Chilobwe Community Technical College in Blantyre. The findings of the study will contribute towards programming and advocacy on prioritizing SRH and GBV education and service provision for TVCs.

## Findings

The study found that both male and female students are sexually active and engage in casual, unprotected and transactional sex influenced by sexual desire, peer pressure, and need for financial support. Male and female students in TVCs engage in serial monogamous relationships and concurrent multiple partnerships. Of great concern is the finding that there are cases of male instructors having sexual relationships with female students with no disciplinary action taken against the instructor.

Findings indicate that economical, socio-cultural, and sexual behavioural factors pose significant challenges to students in TVCs, who live in a social environment in which they lack access to family planning education and SRH services, and harmful cultural practices and premarital sex are encouraged. An average of 43% of survey respondents considered their campuses unsafe and unsanitary. All students in the Chongoni and Chilobwe TVCs reside off campus with parents, spouses or in self-boarding houses within the community surrounding the colleges. Although these accommodation arrangements are considered inexpensive, the students found them unsafe and unsanitary as well.

The study revealed that TVCs do not offer SRH services or training on comprehensive sexuality to first year or continuing students, and availability of condoms is either inconsistent or non-existent. Students lack adequate SRH information, including around the risks of unintended pregnancies, induced abortions, sexually transmitted infections (STIs) and HIV. Both TVC students and staff members have low levels of knowledge on SRH and GBV, which contributes to low risk perception and inconsistent health seeking behaviours. In addition, this has contributed to a lack of lobbying or advocacy for SRH- and GBV-prevention services on campus by college administrators and students.

Students access various medical, SRH, and HIV services from public, Banja La Mtsogolo (Marie Stopes), or private health facilities near their colleges amidst barriers such as lack of money to pay for transport and hospital fees; lack of privacy and confidentiality on the part of service providers; perceived stigma; provider's negative attitudes; and overcrowding and long queues at public health facilities.

The study also discovered that GBV is prevalent at the three sampled TVCs. The common types of violence are sexual violence and emotional violence perpetrated by male students towards female students, among male students, and between instructors and (female and male) students. There are also cases of physical violence that happen in students' homes which negatively affects their studies. It was noted, however, that there was no mention of rape at any of the three TVCs, despite the respondents mentioning instances of forced sex. This could be attributed to a misunderstanding of what rape is. None of the colleges offer GBV-prevention services or information to students or faculty and staff members. There were neither formal written policies or reporting mechanisms; nor systems to respond to GBV victims.

Although Malawi has developed policies and plans and implemented programmes on HIV and AIDS, sexual and reproductive health and rights (SRHR) for young people, GBV, and sexuality education, they do not outline policy guidelines on SRH and GBV in TVCs.

The study established that there is poor planning, coordination, implementation, and monitoring and evaluation (M&E) of GBV and SRH interventions for TVCs at national and district levels, and minimal consultation by stakeholders with TVCs to inform programming and strengthen coordination, including priority actions to enhance their capacity to effectively implement appropriate responses. Partnerships between TVCs and organizations working in both SRH and GBV are generally informal, weak or non-existent, and there is minimal involvement of the private sector and communities surrounding the colleges in provision of SRH and GBV services to students.

# Key recommendations

## Policy development, implementation and coordination

- The Ministry of Labour, Youth, Sports, and Manpower Development (MoLYSMD) is advised to take swift disciplinary action of instructors who engage in sexual relations with students. Reinforcement of the instructor's code of conduct is required.

- Immediate steps need to be taken at the college level to create a safe and conducive learning environment, particularly for female students.

- The MoLYSMD should provide the financial resources, technical guidance and appropriate information dissemination campaigns for all colleges to provide a safe learning environment with proper sanitation facilities, particularly for menstrual hygiene.

- The MoLYSMD should mobilize state technical and financial resources to plan, implement, monitor and report on SRH and GBV in TVCs. The MoLYSMD should also strengthen planning, resource mobilization, coordination and integration of SRH and GBV at TVCs in relevant national policies, strategic documents and plans.

- Colleges should be held accountable to meet the minimum requirements for provision of SRH services and prevention of GBV in TVCs.

- Colleges should engage community leaders, district level partners, and service providers to offer services, support, expert information, and supplies such as condoms.

- The MoLYSMD should develop and enforce policies on SRH and GBV in the TEVET system and TVCs at national and district levels. The Technical, Entrepreneurial and Vocational Education Training Authority (TEVETA) should facilitate the development of a standard policy and code of conduct, as well as guidelines for colleges to address SRH issues and GBV prevention and response which should also be widely disseminated.

## Curriculum development and implementation

- The TEVETA should conduct a rapid training needs assessment to ascertain knowledge and skills gaps, as well as learning needs on SRH and GBV in TVCs for instructors, students and college staff at personal, classroom, college, and community levels.

- The TEVETA should incorporate the pre-developed and Malawi government-approved Comprehensive sexuality education for out-of-school young people in Eastern and Southern Africa curriculum in the training curriculum of all vocational training colleges.

- The TEVETA should develop key messages on SRH and GBV for use by college students, management, and staff to ensure consistent messaging and understanding of issues.
- The MoLYSMD should organize courses and equip master trainers (trainer of trainers) and instructors with knowledge, skills and attitudes to manage SRH and GBV content in TVCs.

- The MoLYSMD should also appoint and train male and female instructors to champion and teach SRH and GBV and comprehensive sexuality education (CSE) in the TVCs.

- Colleges should appoint a committee to address GBV and SRH comprising students, administration, faculty, and support staff.

- Colleges should facilitate the formation and training of college drama and debate clubs and other extra-curricular activities that could facilitate discussions and provide toolkits, scripts and themes for discussion. They should ensure that female students actively participate in the clubs.

## Gender-based violence prevention

- The MoLYSMD should conduct a gender analysis of the TEVET programme and TVCs in order to ascertain the gender gaps and entry points for interventions and mainstreaming of gender in the TEVET system.
- The MoLYSMD should also advise and provide support to colleges for the appointment of gender-balanced college management committees where females take up leadership positions beyond being secretary or committee member.
- In addition, the MoLYSMD should introduce workplace programmes on GBV and lobby for addressing GBV at the workplace.
- Colleges should raise awareness on GBV prevention and mitigation and ensure that college campuses are safe.
- Further, colleges should identify and eliminate barriers to seeking support for victims of GBV and ensure that perpetrators of any form of violence are held accountable.
- Colleges should facilitate the formation of action groups for male students to act as role models on addressing SRH and GBV in the colleges.

## Sexual and reproductive health

- Colleges should liaise with the district youth-friendly health service coordinator to identify health practitioners and community-based distribution agents (CBDAs) to visit and offer services at colleges regularly.
- Colleges should promote distribution of male and female condoms and offer training and orientation in condom use and disposal.

## Advocacy and community mobilization

- The MoLYSMD, with support from the TEVETA, should develop policy briefs and engage development partners, policy-makers, media, human rights and gender advocates, civic leaders, parliamentary committees, district council committees, and health/HIV and gender NGOs and technical working groups (TWGs) or sub-groups to advocate for and support efforts in SRH and GBV-prevention in TVCs.

## College inspection, monitoring and reporting

- The MoLYSMD should strengthen data collection and reporting on SRH and GBV in TVCs. SRH and GBV data should also be integrated into monitoring and reporting mechanisms and supervision tools.

# 1. Introduction

This report is a situational analysis of the status of sexual and reproductive health (SRH) of students and gender-based violence (GBV) in technical and vocational colleges (TVCs) in Malawi. The study was commissioned by UNESCO and was conducted in three technical colleges, namely Chilobwe Community Technical and Vocational College in Blantyre, Chongoni Community Technical and Vocational College in Dedza, and Mzuzu Technical College in Mzuzu.

The research was also extended to national and local stakeholders considered relevant to the SRH and GBV needs of students in TVCs. The report outlines the research methodology, presents key findings, and concludes with recommendations. In addition, literature was reviewed to ascertain the status of policy and programming and available data on SRH and GBV in higher and tertiary education institutions (HTEIs), including TVCs, and the findings of the study could contribute towards programming and advocacy on prioritizing SRH and GBV education and service provision for TVCs.

## 1.1. Background

HTEIs have a key task of cultivating graduates that will contribute to economic development while engaging with the local, national, continental, and global challenges facing them. Students in HTEIs typically fall between the ages of 18 and 30 and evidence shows that young people in this age category lack adequate SRH information, are at elevated risk for unintended pregnancies and for contracting sexually-transmitted infections (STIs),[1] and account for a substantial proportion of all new HIV cases worldwide. Socioeconomic and biological factors make young women particularly vulnerable to HIV infection and other negative SRH outcomes, with some estimates indicating that girls aged 15-19 are four times more likely to be infected by HIV than their male counterparts.

[1] Theresa Nkuo-Akenji et al. 2007. *Knowledge of HIV/AIDS, sexual behaviour and prevalence of sexually transmitted infections among female students of the University of Buea, Cameroon.* African Journal of AIDS Research. 6(2): 157-163; W. K. Sekirlme. 2001. *Knowledge, attitude and practice about sexually transmitted diseases among University students in Kampala.* African Health Sciences. 1(1):16-22.

Colleges are home to a large number of young women and men in the prime of their lives and at their peak years of sexual activity. The period of university and college admission often represents the first time that many young people experience "real" independence from their parents, guardians, relatives, and teachers who supported and guided them during the early teen years. However, many young people are unable to successfully handle the independence that comes with college life, opening them up to negative SRH outcomes.[2] Studies in other parts of Africa have found that young women's rights to a safe learning environment, free from sexual and other kinds of violence, and to comprehensive SRH information and services, are currently limited at tertiary level context.[3] As such, they are an important target population for comprehensive sexuality education (CSE) which is essential to ensure that they have the knowledge to protect themselves from HIV, other STIs, and unintended pregnancies. It is equally crucial for male students and instructors in colleges to receive targeted programmes on positive masculinity, CSE, and women's rights.

There is little evidence in Malawi to give a clear picture on the current situation of SRH and HIV and AIDS in tertiary institutions, especially related to providing quality SRH information and services. Most of the HIV prevalence and sexual behaviour data comes from the Demographic and Health Survey (DHS) and studies on STIs, among others. In 2008, a cross-sectional study was conducted among first-year university students in Malawi to determine distribution of HIV and AIDS-related knowledge and sexual behaviours. The study found that 70% of students at universities felt they knew enough about HIV and AIDS, 67% knew where to find condoms on campus, and over 80% knew where to access HIV testing on campus – but only 19% reported that they knew their HIV status. About half (52.6%) of the students used a condom at last vaginal sexual intercourse, having multiple sex partners in the last 12 months was reported by 40.4% of students, and 68.4% students felt they were not at risk of acquiring HIV infection.[4]

[2] Khamasi, J.W. and Undie, C. 2008. *Teaching human sexuality in higher education: A case from Western Kenya*. In Mairead Dunne (Ed.). Gender, Sexuality and Development: Education and Society in sub-Saharan Africa.

[3] W. Onyango-Ouma. 2007. *Sexuality in the Academia: Challenges and Opportunities. Sexuality Institute*. October 30-November 2, 2007, Mombasa, Kenya.

[4] Ntata et al. 2008. *Gender differences in university students' HIV/AIDS-related knowledge and sexual behaviours in Malawi: a pilot study*. Journal of Social Aspects of HIV/AIDS, pp. 201-205.

In 2016, UNFPA Malawi conducted a qualitative mapping exercise of SRH services in 21 private and public tertiary institutions (not including vocational colleges). The study established that the main factors affecting availability of SRH services in these institutions in Malawi include lack of on-campus health facilities, unsupportive institutional founding philosophies, and lack of adequate health staff, even where the institution has a health facility on campus. The study also found that drug abuse is emerging as the primary cause of SRH-related problems for students, followed by poor condom availability and use, and power imbalance in relationships among male and female students. The study reports that GBV is common in most of the public and private tertiary institutions, largely as a result of drug and substance abuse among students during entertainment events.[5]

Although the UNFPA study illuminates some critical issues at universities, there have been no studies conducted on the situation of SRH and GBV in TVCs in Malawi. It is important to recognize that different settings may lead to different experiences and behaviours, which underscores the importance of particular and specific data for TVCs that this study endeavoured to generate.

## 1.2. Research objectives

The main objective of the study was to conduct a situational analysis of the status of SRH service provision and GBV in TVCs in Malawi under the Technical, Entrepreneurship and Vocational Education Training (TEVET) programme.

Specifically, the assignment sought to:

- Understand the current and future SRH issues affecting students' sexual and reproductive health and well-being in TVCs;
- Establish the extent of GBV experienced by students in TVCs;
- Identify areas to inform dialogue and advocacy with key stakeholders towards improving and prioritizing SRH service provision and GBV prevention in TVCs;
- Gather evidence on students' knowledge gaps and education needs in SRH and GBV in order to shed light on and inform pathways for improved CSE at primary and secondary school levels.

The results of the study will feed into a regional study which includes a desk review of literature collected from all Southern African Development Community (SADC) countries and in-depth quantitative and qualitative data from colleges in Tanzania and Zimbabwe. Terms of Reference for the assignment are attached in Annex 1.

[5] UNFPA Malawi. 2016. *Mapping of Sexual and Reproductive Health Services in 21 Public and Private Tertiary Institutions of Malawi*; Draft Report; December 2016.

# 2. Methodology

The study used a mixed approach of quantitative and qualitative methods. Methods used were desk review, survey, key informant interviews (KIIs), and focus group discussions (FGDs) as detailed below:

- Desk review of publications on Life Skills Education (LSE), technical college student orientation, and SRH of students and GBV in TVCs in Malawi.
- A structured survey questionnaire to gather quantitative information on demographic characteristics of students at TVCs; status of SRH programmes offered; uptake and utilization of services provided; knowledge, attitudes, and sexual risk behaviour of students; and prevalence of HIV, STIs, pregnancies, and GBV.
- FGDs with students in TVCs to gather qualitative information on knowledge, attitudes and opinions on sexual risk behaviour, and SRH services.
- Semi-structured KIIs with college administrators and teachers, policy-makers and service providers in SRH and GBV to gather perceptions and challenges faced by young people in TVCs.

## 2.1. Desk review

Both published and non-published literature on SRH, GBV, HIV and AIDS, and LSE related to young people in institutions of higher learning, including vocational colleges in Malawi, southern Africa and other regions, was reviewed. The aim of this desk review was to obtain information for an in-depth understanding of the problem, theory and practice, national programmes, and existing support structures and evidence on SRH, HIV and AIDS, sexuality education and GBV experienced by students.

## 2.2. Sampling techniques and sample size

The study used purposive sampling guided by UNESCO and respective college administrations. Colleges were identified to be a representative sample of the types of institutions offering vocational training. Although all colleges offer construction courses, they differ in terms of location (rural or urban; north, central or southern region), type of college (national or community based), student housing situation, and student population size.

Mzuzu Technical College is a national TVC located in an urban setting of Mzuzu City in the northern region. It has boarding facilities where 58% of students stay on campus. Chongoni Community Technical College is situated in the rural setting of Dedza District in the central region. Chilobwe Community Technical College is located in a peri-urban area within the City of Blantyre in the southern region. There are no boarding facilities at either Chongoni or Chilobwe Community Technical Colleges.

The survey targeted 20 students (10 female and 10 male) in each of the three colleges. All 60 students were in their first year at the college. The college administration identified the students to take the survey and to participate in the FGDs (one female only and one male only at each college). An additional four FGDs per college were also conducted as follows: at Mzuzu Technical College one female only for first year students; one female only for second to fourth year students; one male only for first year students; and one male only for second to fourth year students; and two female only and two male only at each of the two community technical colleges. Each FGD had no more than seven and no less than four students to allow adequate discussions. In total, 14 FGDs were held. The total sample was not necessarily nationally representative but was substantive enough to permit the drawing of inferences regarding demographics and SRH and GBV as experienced by the sampled students.

## 2.3. Data collection

Data collection for the situational analysis was conducted from 29 May to 16 June 2017 by Ms Bridget Chibwana (consultant) in Blantyre and Mzuzu and by staff members from the UNESCO Malawi Skills and Technical Education Programme (STEP) and the HIV and Health Education Project in Dedza.

The qualitative component of data collection focused on gaining in-depth exploration and understanding of the current and future issues affecting young people's sexual and reproductive health and well-being. It also provided useful evidence on young people's health and education needs and knowledge gaps.

### 2.3.1. Data collection tools

The study used a combination of methods to collect quantitative and qualitative data. Data collection tools were developed by the Health Economics and HIV and AIDS Research Division (HEARD) at the University of KwaZulu-Natal and were adapted for use in Malawi, since HEARD is conducting a similar study in Tanzania and Zimbabwe. The quantitative data was collected through a survey questionnaire and the qualitative data was collected through FGDs and KIIs.

#### Survey questionnaire

The survey questionnaire was administered to a total of 60 students, 20 per college (10 female and 10 male), and enabled the collection of data on the demographic characteristics of the students and their knowledge, attitudes and behaviour, as well as establishing information on HIV, STIs, pregnancies, and GBV on campus. The data provided a basis for triangulation of qualitative data.

#### FGDs with students

A total of 16 FGDs were conducted in all three TVCs. Each college organized four FGDs (two male only and two female only groups). Interviews were conducted by the consultant and two UNESCO staff.

KIIs with stakeholders

A total of 20 KIIs were conducted with national level policy-makers, development partners, and service providers involved in provision of SRH, sexuality education and GBV to students in vocational training colleges in Lilongwe, Mzuzu, Blantyre and Dedza. Participants were selected based on their roles in SRH, sexuality education and GBV for young people. See Annex 4 for the list of people met.

### 2.3.2. Data processing and analysis

The collected data was analysed and synthesized based on information from transcribed notes and questionnaires. Qualitative data from FGDs and KIIs was analysed manually, organized and summarized into broad themes around the key situational analysis questions, and triangulated with quantitative findings. Quantitative data was analysed using STATA version 12. The quantitative data was first analysed and summarized in the form of tables and graphs, and then interpreted accordingly.

Conclusions were made only upon synthesis, cross-checking, and establishment of consistency (or inconsistencies) with other sources and methods deployed as part of the situational analysis. Content from the analysis has been used to generate report findings and recommendations.

## 2.4. Ethical considerations and informed consent

The study was conducted after obtaining permission from the National Research Council of Malawi, the Ministry of Labour, Youth, Sports, and Manpower Development (MoLYSMD), and sampled technical colleges. The assessment included no invasive or medical procedures of any kind. Study participants did not require parental consent since they were above 18 years old.

Although the colleges helped with the recruitment of student respondents, participation in the study was voluntary and confidential and this was emphasized to respondents before they participated. The objectives and nature of the assessment were explained clearly to the respondents who were interviewed only after they had agreed to participate in the study by signing a consent form or giving verbal consent. It was also emphasized to the respondents that refusal to participate in the study would not result in any loss of service or affect their education.

## 2.5. Limitations of the study

The sample size for the student survey was limited to 60 students in three colleges. This was due to limitations in terms of financial resources, as well as the timeframe required for conducting this study. Interpretation of quantitative data therefore needs to be taken with caution. It would have been useful if the scope of this study was increased through increased sample size. At the design stage of this study it was assumed that the study could be conducted in English, as all students who pass the Malawi School Certificate of Education should be competent to understand English. However, some students could not express themselves well in English and therefore Chichewa was used in such situations. The limitation in understanding of English may have affected understanding of questions on the survey questionnaire. The majority of the FGDs and interviews were held in Chichewa.

# 3. Key findings and discussion

Malawi's population is currently estimated at 17.3 million, with 74% of the population below the age of 30 and 41% aged 10-29.[6] The youth in Malawi are faced with many challenges, including limited economic development, a social environment that encourages certain harmful cultural practices, early marriage, and early sexual debut, and lack of access to family planning education and services.[7] Early and unintended pregnancies (EUP), unemployment, HIV and AIDS and other STIs, drug and alcohol abuse, and inadequate technical and vocational training add to young people's vulnerability[8]. A mapping study conducted in 21 tertiary education institutions in Malawi revealed that peer pressure and alcohol and drug abuse also contribute to SRH and GBV problems.[9]

[6] Government of Malawi. 2016. Malawi Youth Status Report, Adolescent and Youth Situation.

[7] Mangochi A.T. 2014. *Impact of Technical and Vocational Education and Training on Youth Vulnerability in Malawi.* M.A. Thesis, University of Reading, UK.

[8] Government of Malawi. 2013. National Youth Policy.

[9] UNFPA Malawi. 2016. *Mapping of Sexual and Reproductive Health Services in 21 Public and Private Tertiary Institutions of Malawi*; Draft Report; December 2016.

According to the Malawi Development Health Survey (MDHS) 2015-16, the median age at first sexual intercourse is 16.5 years for women and 18.5 years for men aged 25-49. In this same age range, 19% of women and 11% of men have had first sex before the age of 15, 85% of women and 66% of men have had sexual intercourse by the age of 20 and the median age at first marriage is 18.2 years for women and 23.5 years for men. For women, the main reasons for early marriage include EUP, early school drop-out, poverty, and harmful and negative traditional cultural practices which promote early sexual initiation. Although education (especially the inability to proceed with it) has never been regarded as a reason for females marrying younger, according to the Malawi Youth Status Report (2016), every year that a girl stays in school delays them from marriage, sexual debut and unplanned pregnancies[10]. In Malawi, only 5% of females and 9% of males have completed secondary school or gone beyond secondary school.[11] Malawi has increased total enrolment for tertiary levels from late 1990s, with total enrolment increasing from 3 387 in 1997 to 10 473 in 2012.[12] Despite this improvement in tertiary level enrolment, the TEVET system enrols very few students. In 2012, the annual intake was around 700, reaching only 3.9% of secondary school graduates (or 35 TEVET students per 100 000 inhabitants), the lowest access rate in SADC and three times less than the African average.[13]

Malawi ranks 124th on the Gender Inequality Index with a value of 0.57, which reflects the high levels of gender inequalities in reproductive health, empowerment and economic activity. GBV and high inequality are great concerns from a human rights, economic, and health perspective, with 34% of women having experienced physical violence since age 15, and 20% having experienced sexual violence.[14] The most common location reported among 18-24-year-old females who experienced sexual abuse prior to age 18 was in the perpetrator's home (28.3%), followed by her own home (22.1%), in school (20.4%), and on a road (15.6%). For males of the same ages, the most common location reported were in his own home (23.2%), followed by in the perpetrator's home (21.1%), on a road (18.3%), in school (13.9%), in a field or other natural fields (11%) and someone else's home (10.9%).[15]

GBV is compounded by, among other factors, harmful cultural practices, religious beliefs, socialization process, unavailability of services, and poor access to such services. The impact of GBV can cause immediate and long-term physical and mental health consequences for survivors of GBV, such as post-traumatic stress disorder, risk of re-victimization, depression, substance abuse, and suicidality.[16] In Malawi, young women and adolescent girls in education settings face lack of boarding facilities, which exposes them to various forms of abuse resulting from inadequate safety in their boarding areas as well as unsafe transport options to their college.[17]

[10] Government of Malawi. 2016. Malawi Youth Status Report, Adolescent and Youth Situation.

[11] National Statistical Office, Malawi, and ICF. 2017. Demographic and Health Survey 2015 to 2016 (MDHS 2015-2016).

[12] UNESCO. 2014. Mapping Research and Innovation in the Republic of Malawi.

[13] UNESCO. 2010. TVET Policy Review, Malawi.

[14] Government of Malawi. 2013. Violence against Children and Young Women in Malawi: Findings from a National Survey.

[15] *Ibid.*

[16] Lori Heise, Mary Ellsberg and Megan Gottemoeller. 1999. Ending Violence against Women Population Report. Volume xxvii, No. 41.

[17] Government of Malawi. 2016, Malawi Youth Status Report, Adolescent and Youth Situation.

# 3.1. Policy frameworks, services, and coordination

## 3.1.1. Provision of sexuality education and sexual and reproductive health services legal and policy frameworks

Malawi is a signatory to various international and regional instruments that provide guidance on the provision of SRH services for young people and the prevention of GBV. These include the Universal Declaration of Human Rights; Convention on the Elimination of All forms of Discrimination against Women (CEDAW); 1994 International Conference on Population and Development Programme of Action; United Nations Sustainable Development Goals – Agenda 2030; African Union Health Strategy; SADC Health Strategy; and the Eastern and Southern African Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People.

At national level, Malawi has passed several laws and developed policies and plans that address SRH and GBV, notably the National Youth Policy (2013), National Sexual and Reproductive Health and Rights (SRHR) Policy 2016 (draft), Youth-Friendly Health Service Strategy (2015-2020), National Standards on Youth-Friendly Health Services (2015-2020), HIV National Strategic Plan (2015-2020), HIV Prevention Strategy (2015-2020), National Education Sector Plan (2008-2017), National TEVET Policy (2013), Technical, Entrepreneurial and Vocational Education Training Authority (TEVETA) Strategic Plan (2013-2018), Gender Equality Act (2013), National Gender Policy (2012-2017), and National Plan of Action to Combat Gender-Based Violence (2016-2020).

The desk review established that while Malawi has developed policies and plans and implemented programmes on HIV and AIDS, SRHR for young people, GBV, and sexuality education, the documents contain general statements and strategic actions on SRH and gender without specific reference to students in TVCs. The documents do not outline clear policy guidelines on SRH and GBV and linkages between SRH and GBV in TVCs. For example, the National SRHR Policy (2016) stipulates a strategic action on reducing the incidence of HIV, STIs, unplanned pregnancies and their complications, and drug and alcohol use among young people. The National Youth Policy (2013) calls for the promotion of general health and non-discriminatory SRHR of young people.

Specific to equality, the Gender Equality Act (2013) promotes gender equality and equal integration, influence, empowerment, dignity, and opportunities for men and women in all functions of society, and prohibits and provides redress for sex discrimination, harmful practices, and sexual harassment.

The National Girls Education Strategy (2008-2019) calls for the expansion of existing university infrastructure space, implementation of affirmative action procedures for selection to higher education institutions, and mitigation of the effects of poverty for female students' education. The TEVET Policy (2013) has a statement on increasing opportunities for females and vulnerable, marginalized, and disadvantaged groups in the TEVET system. Similarly, the TEVETA Strategic Plan (2013-2018) has strategies on creating an enabling training environment and implementing a gender-based recruitment and enrolment with a target of 50% from the 30% at baseline.[18]

Neither the TEVET Policy (2013) nor the TEVETA Strategic Plan (2013-2018) contain provisions for SRH or GBV, and although the TEVETA developed an HIV and AIDS Policy (2011), the goal of which is to prevent the further spread of HIV infection and mitigate the impact of HIV and AIDS, it only targets employees and their families, and not students in TVCs.

Overall, the SRH and GBV policies and programmes target students attending tertiary education as a homogenous group without taking into account sex, age, geographical, and social setting. There is minimal reference to SRH and GBV in student and staff codes of conduct and an absence of monitoring and evaluation (M&E) indicators targeting TVCs. These gaps in the policy framework have perhaps resulted in the lack of SRH services available to students, protection of students from GBV, absence of CSE in the TVC curricula, and monitoring or supervision of these important issues by government and other relevant agencies.

### 3.1.2. Existing CSE and HIV programmes and services

LSE, including CSE, was introduced in schools in 2002. It was originally a non-examinable subject but was later made examinable, in 2010, as a way of ensuring that it is taken seriously by both learners and teachers.[19] By 2010, all public and private primary and secondary schools were required to teach Life Skills as a core and examinable subject, leading to the subject reaching out to most primary and secondary students.

There have been various measures and initiatives undertaken to prevent and control HIV and AIDS within the HTEIs, particularly in public colleges, however, the interventions have been sporadic and laidback, focusing mainly on information, education and communication (IEC) to create awareness about HIV and AIDS among staff and students. Neither have these interventions reached all tertiary institutions, particularly vocational colleges. While there is an assumption that the SRH and HIV topics, or even gender and GBV, will be covered through other modules, the components of such modules leave a lot to be desired and are out of lecturers' or instructors' interests.[20]

[18] Government of Malawi, TEVETA Strategic Plan (2013-2018).

[19] Centre for Social Research. 2011. Life Skills Education and Reproductive Health Education: Preliminary Findings from the Non-biomedical Interventions into HIV and AIDS Study.

[20] UNFPA Malawi. 2016. *Mapping of Sexual and Reproductive Health Services in 21 Public and Private Tertiary Institutions of Malawi*; Draft Report; December 2016.

Since 2007, Malawi has implemented the Youth-Friendly Health Services (YFHS) programme as a strategy to render all health services more acceptable, accessible, attractive, and affordable to young people. The providers of YFHS are community-based distribution agents (CBDAs), peer educators, health centre-based youth service providers, and hospital-based youth service providers. The programme calls for provision of training and guidelines to all service providers and offers health and non-health services in line with the minimum package, which is a combination of clinical services and health promotion interventions. These include health promotion, delivery of health services, referral, and follow up. See Box 1 for a list of services offered under the YFHS package.

The 2009 SRHR policy for Malawi stipulates that all people shall have access to health services without distinction of ethnicity, gender, disability, religion, political belief, and geographical location, among others. However, as with many other policy provisions, this remains an ambition. Furthermore, the Malawi Tertiary Institutions Youth SRH mapping study established that students in faith-based institutions and secular tertiary institutions that do not have health facilities depend on other surrounding health facilities, shops and pharmacies to access different types of SRH services, particularly family planning and STI services.

There have been considerable gaps in evidence on provision of SRH and prevention of GBV in vocational colleges in Malawi. Additionally, awareness and use of the YFHS programme is low, with less than one third of community youth survey respondents reporting to have heard about YFHS and only 13% reporting to have ever used YFHS.[21] Sexually experienced older and out-of-school youth accessed YFHS more often than their counterparts, suggesting that where young people are in their lifecycle plays a significant role in their knowledge and use of YFHS.[22] Other factors that contribute to low uptake of YFHS among young people include low self-confidence, weak parental and community support, inadequate transport, and contradictory religious beliefs.[23] This, to a larger extent, provides an explanation as to why there are low SRH-seeking behaviours among young people.

Through the review of curricula and rules and regulations for TVCs, as well as responses from students, faculty members, college administrators, MoLYSMD and TEVETA, the situational analysis concluded that there are no interventions on CSE targeting students in the three TVCs. The colleges lack systematic, well-coordinated interventions, campaigns and IEC materials, and the current harmonized curriculum on Occupational Safety and Health (OSH) does not cover any module on SRH, HIV and AIDS, or GBV. The previous curriculum had a brief section on STIs and HIV and AIDS which was taught to first year students, however, students and instructors who took part in the FGDs and KIIs lamented that content of the previous module on OSH had gaps in it that did not adequately address the needs of students in SRH or HIV and AIDS. Instructors for this component had also not undergone formal training or orientation on HIV and AIDS in colleges or workplace.

[21] Government of Malawi. 2014. Youth Friendly Health Services Evaluation.
[22] *Ibid.*
[23] *Ibid.*

## Box 1: Malawi YFHS package

- Contraceptive services including condoms; HIV testing and counselling;
- Prevention, diagnosis and management of sexually transmitted infections;
- Maternal and neonatal health care;
- Antenatal, delivery and post-natal care services;
- Prevention of mother-to-child transmission of HIV (PMTCT);
- Referral to health facility or other service delivery points;
- Comprehensive sexuality education;
- Youth outreach services, including support of teen clubs;
- Treatment of sexual abuse victims (including post-exposure prophylaxis);
- Voluntary medical male circumcision (VMMC);
- Antiretroviral therapy (ART); cancer screening and human papilloma virus (HPV) vaccine;
- Post-abortion care; nutrition;
- Sexual abuse;
- Adolescent growth and development;
- Mental health and psychosocial support; including support for drug and substance use and abuse.

Furthermore, there is no standard or official written-down student orientation package targeting first year students in TVCs. Each college puts together its own student orientation programme and, as a result, areas of emphasis vary in terms of content, level of detail, and timing. According to college administrators, key topics for the orientation programme include campus geography and amenities, appropriate social behaviour, college rules and disciplinary procedures, and available logistical support. None of the colleges sampled have ever tackled SRH, HIV, or GBV as specific topics for discussion during orientation programmes.

### 3.1.3. Coordination of sexual and reproductive health and gender-based violence in technical and vocational colleges

The situational analysis ascertained that TVCs within the TEVET system are multisectoral in nature and have components that relate to other ministries and players. For instance, the TVC in Mzuzu was founded by the Catholic Church and still has links with the church. Chilobwe TVC was established by the City Council and reports to the MoLYSMD and City Assembly. Chongoni TVC reports to the District Council and MoLYSMD. The MoLYSMD is responsible for financial support, provision of policy guidance, technical assistance, and strategic direction on matters related to training, recruitment and placement of students, instructors, and other administrative staff. TEVETA on the other hand is responsible for curriculum development and review, standards, training of instructors, placement of students in industry for attachment, management of bursaries, and M&E, among other roles. TVCs have no elements that are managed by the Ministry of Education, Science and Technology (MoEST), although this used to be the case in the past.

At national and district levels, there is no structure for coordinating, implementing, monitoring and evaluating, and information sharing of GBV and SRH interventions for TVCs, which could have contributed to challenges of accountability and guidance. There also appears to be minimal involvement of the private sector, civil society, and communities within the TVCs. There are no formal agreements or memoranda of understanding (MoU), between colleges and service providers to guide collaboration and support in provision of SRH and GBV services. Furthermore, there are minimal consultations by stakeholders with TVCs to inform programming and strengthen coordination, including priority actions to enhance TVCs' capacity to effectively implement appropriate responses.

The study nevertheless established, through KIIs, that partner organizations at the district and community levels, such as victim support units (VSUs), health facilities, district youth offices, non-government organizations (NGOs), and community-based organizations (CBOs) have some technical capacity which could be employed in responding to or advocating for gender and SRH interventions and providing SRH and GBV services at TVCs.

## 3.2. Demographic characteristics of students

### 3.2.1. Student enrolment and number and sex of college staff

The current enrolment at the three colleges is presented in Table 1 below. The majority of female students are enrolled in the tailoring courses, with very few (approximately three in a class of 20) participating in the plumbing, bricklaying, and electrical courses.

**Table 1: Enrolment at sampled colleges**

| Name of college | District | Category | Number of students at college | Year(s) | Sex | |
|---|---|---|---|---|---|---|
| | | | | | Male | Female |
| Chongoni Community Technical College | Dedza | Rural | 103 | 1 | 56 | 35 |
| Chilobwe Community Technical College | Blantyre | Urban | 100 | 1 | 73 | 27 |
| Mzuzu Technical College | Mzuzu | Urban | 650 | 1, 2, 3, 4 | 401 | 249 |

The study revealed that 66.7% of the students in the sampled TVCs are between the age of 21 and 25 years. There are no significant differences on the percentages per age range in terms of the sexes (63% female and 70% male), which shows that the males and females in the vocational colleges are generally of the similar age ranges.

### 3.2.2. Average age of college students

The study revealed that 66.7% of the students in the sampled TVCs are between the age of 21 and 25 years. There are no significant differences on the percentages per age range in terms of the sexes (63% female and 70% male), which shows that the males and females in the vocational colleges are generally of the similar age ranges.

### 3.2.3. Marital status and number of children of college students

In terms of marital status, nearly 88% of the survey sample (87% females and 89% males) reported to be single, with 7% married (both females and males) and the remaining 7% females divorced and 4% males separated. Of the female respondents, 33% reported having one or more children, while 7% of male respondents reported having children.

### 3.2.4. Place of residence for college students

Chongoni and Chilobwe TVCs have no boarding facilities, and therefore all students stay off campus, either with their parents or in private boarding accommodation. However, at Mzuzu Technical College, 58% of male students and 20% of female students reside on campus. This implies that an average of 87% of the sampled students in the three TVCs reside off campus.

Of the students who participated in the survey, 40% of females and 51% of males live in self-accommodation either by themselves or shared, and 47% females and 29% males live with their parents or a guardian. According to the FGDs and KIIs, students in private boarding facilities reside in less secure and less hygienic environments, which was either due to unavailability of appropriate accommodation or inadequate pocket allowance to afford decent accommodation.

### 3.2.5. Students' household income

With regard to household income, 46% females and 60% males of the sample reported that their households earn an equivalent of or less than Malawi Kwacha (MK) 2 000 000 (USD 2 702) per annum, and 14% females and 21% males reported household income between MK 3 000 000 to MK 5 000000 (USD 4 050 to USD 6 757).[24] These figures seem to be on the higher side for average household earnings for Malawi. According to the Malawi Human Development Index Report, the average income per household is less than USD 2 (USD 1.25) per day.[25] However, the household income does not necessarily reflect the student's financial ability, in that although one's family may be well off, this does not mean that one has access or control over part of the income.

The study found that only 20% of female respondents at Chongoni had part-time employment and none of the female respondents from Chilobwe or Mzuzu had part-time work. None of the male students at Chilobwe engaged in part-time work either, while at Chongoni and Mzuzu, 11% and 8% respectively of the male students had part-time work.

[24] 1 USD = MWK 740.

[25] Human Development Index Report, 2016.

The TEVETA provides bursaries to students from poor households and in the 2015/16 financial year, paid bursaries to 331 students in technical colleges, out of which 106 were females and 225 were males.[26] However, Chongoni Community College students did not receive any bursaries, Chilobwe received only two bursaries, and Mzuzu received 19 bursaries for female students and 13 for their male students.[27]

Students at one college had limited and incorrect knowledge about the bursary programme, and some students stated that attachments were only arranged by the TEVETA for students who had received a bursary. Most female students did not know that the TEVETA provided bursaries, but their male colleagues were more knowledgeable about the bursaries.

## 3.3. Students' sexual behaviours and practices

The study found that both male and female students are sexually active. An average of 73% of the females and 96% of the males reported to have had sex. Of those who are sexually active, the majority (95%) of both sexes engaged in vaginal sex and the remainder reported engaging in oral sex, while none of the respondents reported engaging in anal sex. A total of 75% of the female and 61% of the male students reported to have had sex by age 20 (see Figure 1).

In terms of the number of sexual partners, 51% of female and 55% of males reported having sex with one person, 26% of females and 14% of males have had sex with two people; and 23% percent of females and 31% of males have had sex with three or more people.

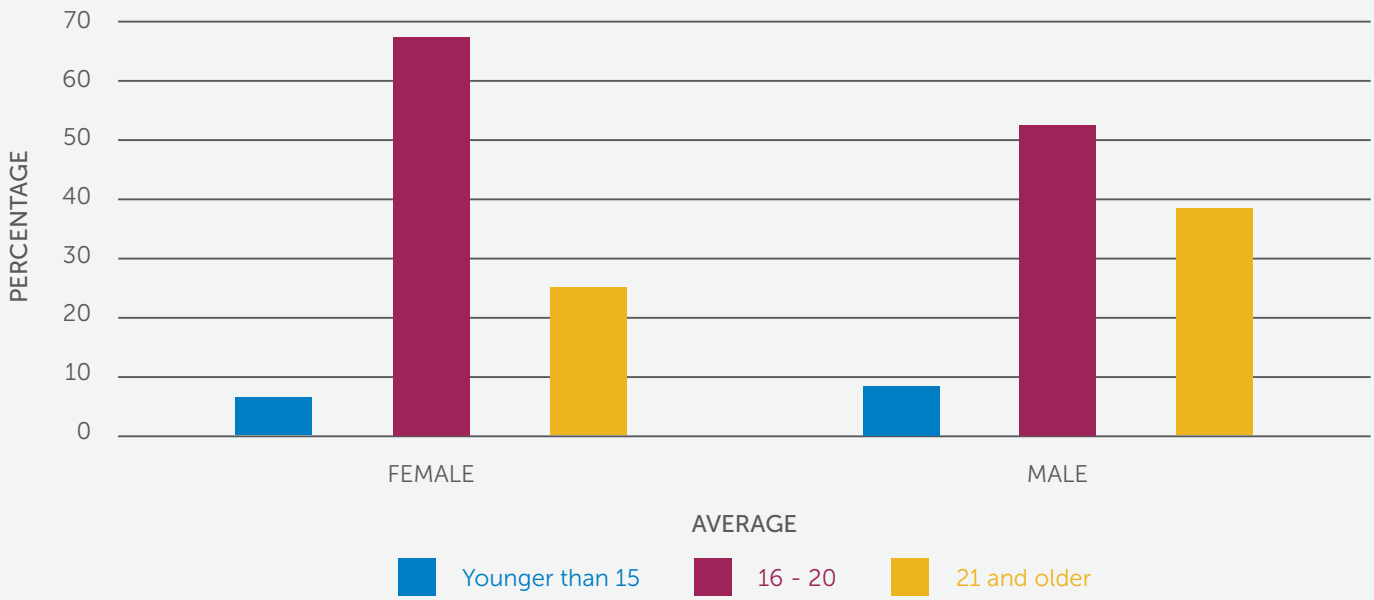
During the FGDs, students cited several reasons for having sex, such as to satisfy sexual desires, peer pressure (for both males and females), to earn money and support (for female students), and to have someone to cook, wash and clean the house (for male students).

> **We are here because of the TEVETA. We could not even afford coming here, and this for many of us is a big push.**
>
> **Female student, FGD**


[26] TEVETA Annual Report, 2015-2016.

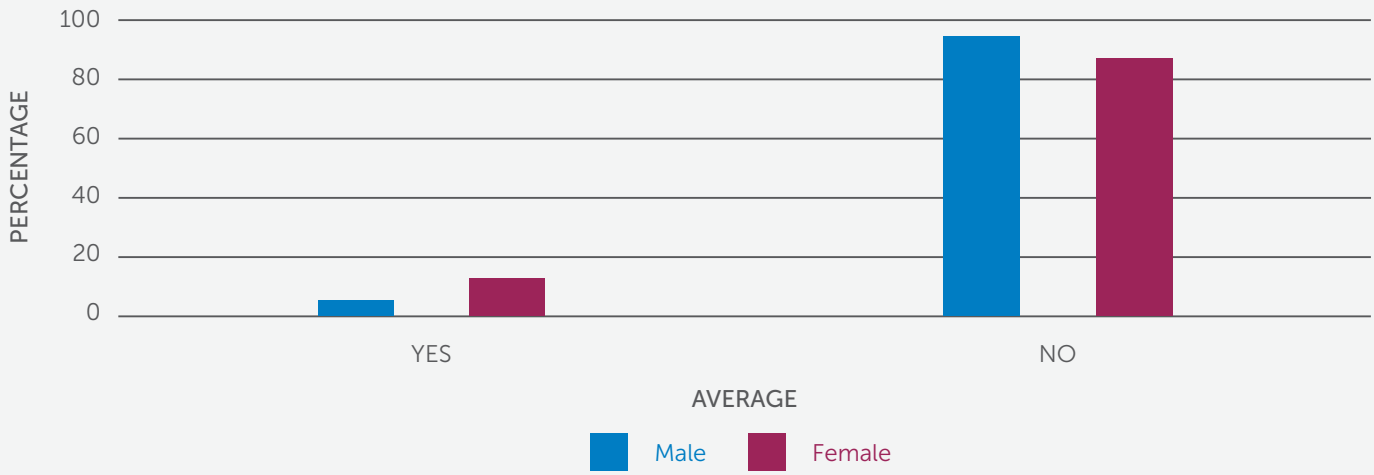
[27] *Ibid*, pp. 17-18.

**Figure 1: Age of first sexual experience**




A low percentage of respondents (12% of male students and 8% of female students) stated that they had sex only with their primary partner (Figure 2). This raises concerns of multiple and concurrent sexual partnerships among students in TVCs, particularly in the context of limited access to contraceptives and SRH information. Students, college administrators, and community leaders mentioned that male students have sex with their spouses, fellow students, and girlfriends from outside their colleges. Female students have sex with their spouses, single or married older males, including fellow students, and men from outside campus, which may include farmers from within the vicinity of the college, bicycle taxi riders, motorcycle taxi riders, and minibus drivers. There have also been cases where female students have been forced to have sex by instructors from their colleges, which is discussed further below in the section on GBV.

**Figure 2: Sex with primary partner**



### 3.3.1. Use of contraceptives

The study found that 40% of the female students and 20% of male students did not use any contraceptives. Of those that did use contraceptives, 43% of females and 80% of males used condoms, 3.3% of the female students used oral contraceptive pills, and another 3.3% used the rhythm method. On condom use, 32% of female students and 30% of male students reported not using a condom during their first sexual intercourse. Of the sampled students, 34% of females and 47% of males reported using condoms every time they had sex (Figure 3). On number of times they have had sex without using a condom in the past 12 months, the rates were very high (84% of female and 78% of male students), despite 86% of the females and 100% of the males reporting not being afraid to use a condom. Some of the reasons mentioned by students in the FGDs for not using condoms included non-availability of condoms at the college, lack of money to buy condoms, no opportunity to buy condoms, to prove one's love to sexual partner (very common among female students), and the fear of losing sexual partner (for female students) or being forced by their sexual partners. This also presents the gender dimensions of sexual activities among male and female students. Students who participated in the study lamented the inconsistent and non-availability of condoms at colleges. They reported that they share condoms among themselves, buy from shops, or collect from CBDAs.

> **I had a girlfriend and we were chatting at night and suddenly we started kissing and then one thing led to another. We thought about condoms but there was nowhere I could go on this campus to get condoms. They say this is a mission college so condoms are not allowed. I couldn't control myself so we ended up doing it with no protection.**
>
> **Male student, FGD**

> **Sex happens impromptu and having plain sex (sex without a condom) shows you really love each other although it can lead to HIV.**
>
> **Male student, FGD**

**Figure 3: Reported use of condom everytime having sex**

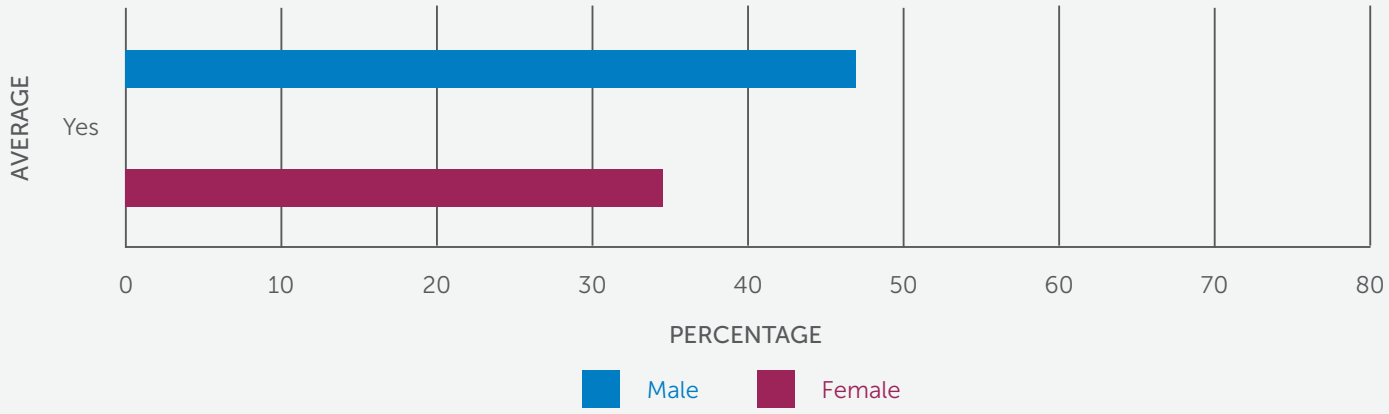
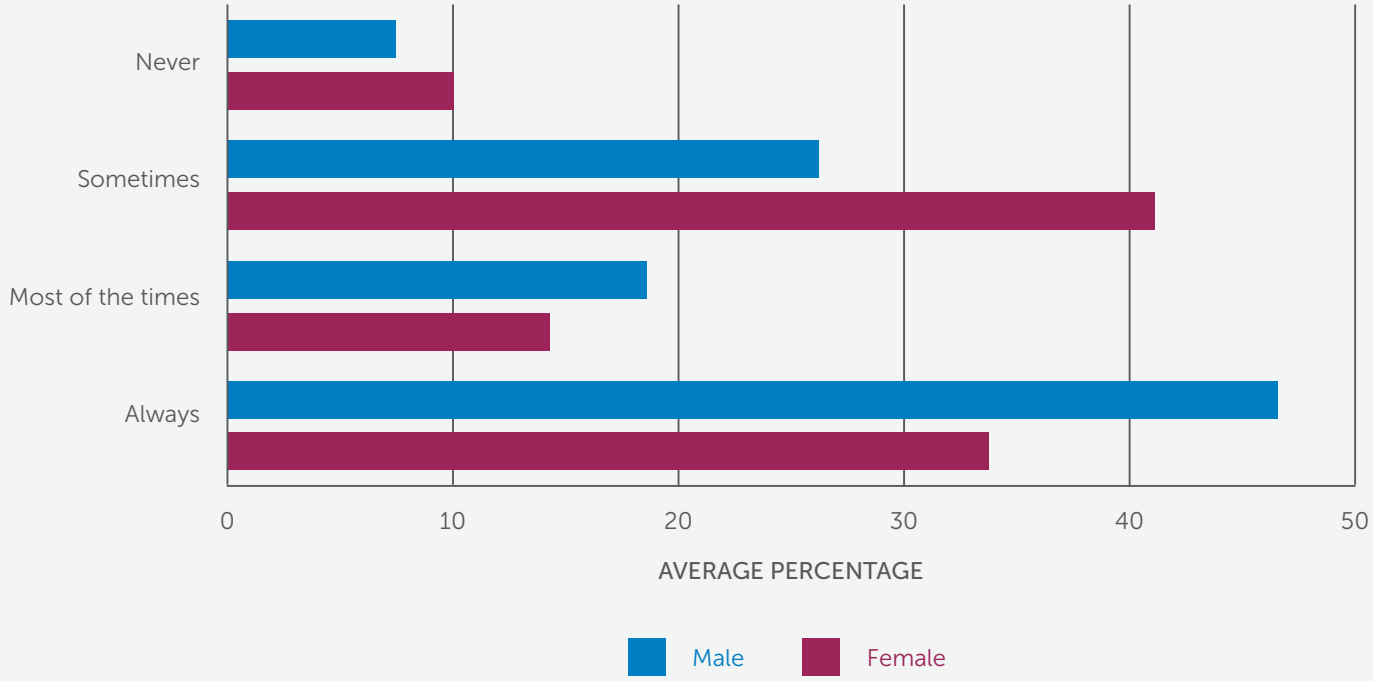



**Figure 4: Frequency of use of condoms**




Students mentioned during FGDs that unplanned pregnancies were a cause for worry. Female respondents were more concerned about becoming pregnant, whereas male students were more concerned about contracting STIs and HIV. The female students also said that the fear of falling pregnant after unprotected sex affected their concentration in class and when reading until the next menstruation commences. One college reported two cases of unplanned pregnancies in the current semester among married students.

When women were asked whether they have had any unplanned pregnancies, 20% of them reported having an unintended pregnancy and 7% reported having terminated a pregnancy (see Table 2). In terms of access to abortion services, 3.3% of the female students indicated that they have access to paid abortion services, 30% have no access to abortion services, 3.3% did not know where to access abortion services, and 63% had never needed the service.

**Table 2: Pregnancy and pregnancy termination (%)**

| | |
|---|---|
| Have experienced an unintended pregnancy | 20 |
| Have terminated a pregnancy | 7 |

The UNFPA Mapping of Sexual and Reproductive Health Services in 21 Public and Private Tertiary Institutions of Malawi (2016) also established that cases of unplanned pregnancies, unsafe abortions, and STIs, including HIV, are on the increase in most of the tertiary institutions, mostly due to high incidences of risky sexual behaviour among students perpetuated by drug and substance abuse; limited access to SRH services, including condoms; peer pressure; and power imbalances between boys and girls in sexual relationships.[28]

## 3.4. Access to sexual and reproductive health services

The study found that students access health services from health facilities outside of campus because there are no clinics in the sampled TVCs. In one college, the only health service provided was a matron who managed a first aid kit. It was noted that condoms were not systematically supplied at all the colleges and there are no formal mechanisms for distributing condoms when available. Chilobwe Community Technical College received condoms in July 2016 and June 2017. A male instructor at Chongoni Community Technical College took it upon himself to distribute condoms to male students when requested and if available. At Mzuzu Technical College, KII respondents were of the view that condoms were not available on campus, partly due to its links with a faith-based institution whose principles do not openly promote use of condoms.

Students in the sampled TVCs expressed dissatisfaction with the absence of SRH services offered on campus. As no services are available on campus, they were required to access various services from public, Banja La Mtsogolo (Marie Stopes), or private health facilities near their colleges which are located on average within a distance of 1.5 to 5 kilometres. The study found that the health services sought included general medical conditions, STI and HIV testing and counselling, antiretroviral drugs (ARVs), cervical cancer screening, family planning, antenatal and postnatal care, and post-abortion care and referrals.

[28] Mapping of Sexual and Reproductive Health Services in 21 Public and Private Tertiary Institutions of Malawi; Draft Report; December 2016.

With regard to preference of service provider, the students reported that they do not prefer the public health service points because they are very slow and they wait too long in queues, particularly at the health centres. They preferred central (tertiary) hospitals where they obtain quality care without having to wait for too long. In the event that they have not been referred to the central hospital by a lower level health facility, they are required to pay a MK 1 500 consultation fee. Students at Chilobwe Community Technical College and Mzuzu Technical College were of the opinion that free services by Banja La Mtsogolo (BLM) and the Family Planning Association of Malawi (FPAM) were better options owing to their confidentiality and youth-friendly service provision. Students at Chilobwe Community Technical College pointed out that they sought health services only when they were sick as they would rather be in class than spend time in long queues to meet a clinician to seek information or undergo a medical check-up. These assertions tally with findings in the YFHS evaluation report (2014), which found that young people's access to SRH services is enhanced by proximity and awareness by the targeted population.[29]

> **To be honest, we can say there is no support given to us on this [SRH]. They do not give us any condoms, they don't treat us, and we have to go to private or public hospitals in town if we need a service. And then, the college only provides transport when you are very ill and are really down. If you are sick and walking, you don't get that transport but these STIs require quick treatment before they get worse and even if they got worse, how do you tell them you have an STI and you need transport?**
>
> **Male first year student, FGD**

> **It's all by yourself. You just have to be responsible and think of what health needs you have and seek them wherever you can. It's a challenge when you don't have money because if you want better services you have to go to private service providers but then… the college should have done something really.**
>
> **Female first year student, FGD**

[29] *Ibid.*

> **Let me say the truth, we don't have a well targeted intervention for our students and that is worrisome. Not even adequate information is passed on. But these students go back into the community, what happens if they get infected while here? Will they not carry the virus to the communities we have invested a lot in to curb the virus? Besides, are we not also spending a lot of money training them?**
>
> College principal, KII

## Box 2: Summary on access to SRH services

Where accessed

- Nearest public health centres and hospitals. The preference is to access the central hospital but can also get services from BLM and FPAM as well as private health facilities for privacy and better youth-friendly treatment.

Type of service sought

- General medical conditions and illnesses, STI treatment, HIV testing and counselling (HTC), family planning, contraceptive supply, ARVs, cervical cancer screening, antenatal and postnatal care, post-abortion care and referrals.

Barriers to accessing SRH services

- Long distances and lack of transport;
- Perceived lack of privacy and confidentiality on the part of service providers;
- Fear of being teased by peers when seen in the queue to access ARVs (perceived stigma);
- Health service provider negative attitudes. However, mixed views on YFHS. They are treated well by the service providers at central hospitals;
- Absence of female nurses in health facility (health centre near Chongoni has male nurse only. Female students do not feel free to be attended by a male nurse);
- Lack of money for transport and to pay fees;
- Overcrowding and long queues at health facility.

Regarding sexual health, when students were asked whether they have been treated for STIs, 13% of females and 9% of males said they had previously been treated for STIs and 80% females and 77% of males have been tested for HIV. Although the majority of the students had tested for HIV, only 6.7% of the female and 2.8% of male students reported to have accessed the service on campus.

**Figure 5: Previous treatment for STIs**

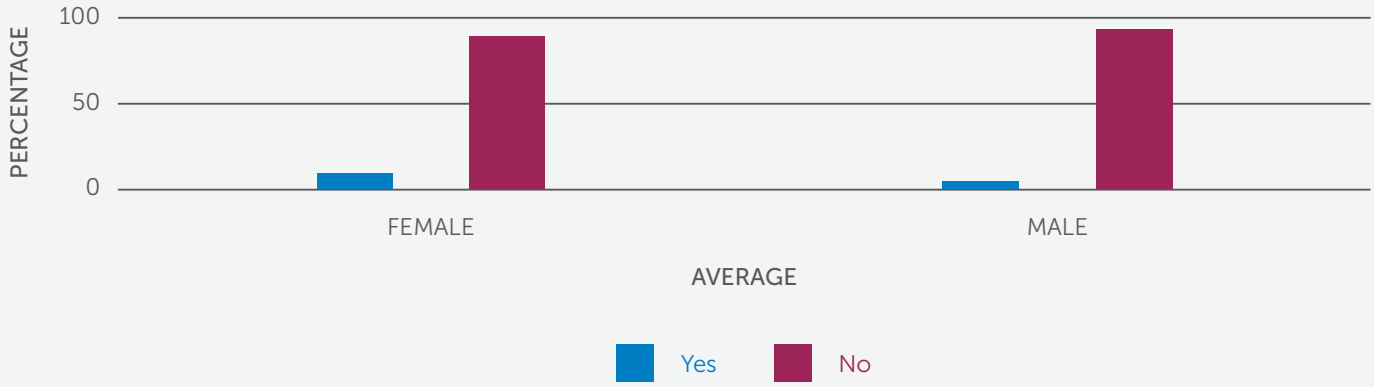
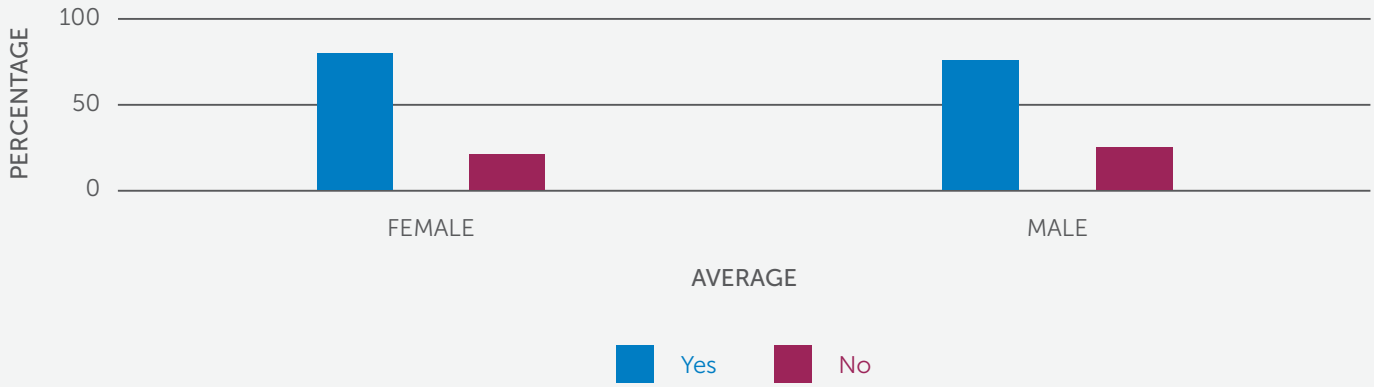



**Figure 6: Previous testing for HIV**




## 3.5. Knowledge of sexual and reproductive health

When asked if the students have ever heard of any initiatives on campus related to preventing HIV, 50% and 29.7% of females and males respectively reported to have been exposed to such interventions. During the FGDs it was noted that students' knowledge levels on SRH were low. The majority of students demonstrated limited understanding of SRH and its associated terms and had difficulty discussing freely and articulately SRH issues. Overall, there was no student respondent who was able to properly define SRH. It took further probing for them to be able to respond on SRH issues. The KIIs revealed that college administrators and instructors also found it difficult to explain and clarify SRH issues.

Students' listed the following as common SRH issues affecting students in TVCs: type and number of sexual partners, unplanned pregnancies, safe motherhood, HIV prevention, ART, treatment of STIs, condom use, male circumcision, and cervical cancer screening. The last two SRH issues (male circumcision and cervical cancer screening) were, however, only mentioned after much probing. Respondents were not able to link GBV to SRH and used language that was discriminatory, as well as expressing beliefs in many myths and misconceptions on SRH, HIV and GBV. Nevertheless, towards the end of the FGDs, the students used the opportunity to ask questions on SRH and GBV, which showed their quest for knowledge in the topics under discussion.

Specific to sources of SRH and HIV and AIDS information, students mentioned that they access this through the radio, friends, television, youth groups, print media, teachers, family members, and health services. It was noted during the face-to-face interaction that both male and female students have access to mobile phones and use social media applications like WhatsApp and Facebook which could be used to access information on SRH and gender topics.

## 3.6. Gender-based violence

The United Nations defines GBV as any act of violence that results in physical, sexual, or psychological harm or suffering to women, girls, men, and boys, as well as threats of such acts, coercion, or the arbitrary deprivation of liberty. GBV has also been acknowledged worldwide as one of the forms of violation of basic human rights.[30] Unfortunately, for most African countries such as Malawi, some forms of GBV have been culturally accepted and somewhat endorsed, hence making it difficult for victims to even report. For example, 9 out of 10 females and 8 out of 10 males aged 18-24 years that participated in the Violence against Children and Young Women in Malawi Survey (2014) endorsed one of the following gender biases: that men should decide when to have sex, that men need more sex than women, that men need other women, that women who carry condoms are "loose", and that women should tolerate violence in order to keep their family together.[31]

In Malawi, domestic violence is widely acknowledged as a great concern, not only from a human rights perspective, but also from economic and health perspectives. To address this issue, Malawi has enacted a series of legislative acts (see section 3.1 on legal and policy framework). Despite these and other efforts, there is widespread recognition in Malawi that much remains to be done and that reliable data is needed to monitor progress.[32]

[30] United Nations. 2006. *Secretary-General's In-depth Study on All Forms of Violence against Women*. New York, USA: United Nations.

[31] Government of Malawi. 2013. Violence against Children and Young Women in Malawi: Findings from a National Survey.

[32] National Statistical Office, Malawi, and ICF. 2017. Demographic and Health Survey 2015-2016.

The MDHS 2015-16 reported that 34% of women have experienced physical violence since age 15, and 20% have experienced sexual violence. According to the 2014 Violence against Children and Young Women in Malawi Survey, the most common form of sexual abuse experienced by both females and males before the age of 18 is unwanted attempted sex, followed by unwanted sexual touching. Of those who had their first sexual intercourse prior to age 18, 1 out of 3 females and 1 out of 10 males experienced their first sexual intercourse as unwilling, meaning that they were forced or coerced to engage in sexual intercourse.[33] The average age of first incident of sexual abuse was 12-14 years and for young people aged 13-17. The most common location for the incidents of sexual abuse occurring is on the way to or in school. Furthermore, 1 in 5 (21.8%) females aged 18-24 experienced sexual abuse prior to the age of 18; with two-thirds (68.4%) of victims experiencing multiple incidents of sexual abuse. The perpetrator is often reported as a spouse, boyfriend or romantic partner (33.4%), followed by a classmate/schoolmate (15.5%).[34]

GBV is compounded by harmful cultural practices (e.g. forced early marriages), forced prostitution, sexual harassment, and sexual exploitation. Among the causes of GBV are poverty, traditional beliefs, and the socialization of girls and boys that make victims accept violence as a norm.[35]

### 3.6.1. Gender-based violence in technical and vocational colleges

It was noted from the student survey, FGDs and KIIs responses that the term GBV was considered a distant reality and that the respondents did not fully understand the dimensions of GBV. Students, faculty members, and administration staff felt inhibited in their responses on instances of GBV at the three colleges. Their initial response was that GBV did not happen at their colleges. The respondents opened up and narrated personal experiences of GBV after being provided with the definition of GBV and further probing.

Respondents felt that some instances were not considered GBV despite the serious impact the instance had on the victim. The qualitative analysis has led to the conclusion that both male and female students are vulnerable to GBV with female students, especially those from poor households, being the most vulnerable. The following forms of GBV were cited as common at the three TVCs:

Sexual violence

- Female students are forced to have sex by their romantic partners;
- Unsolicited touching;
- Sexual exploitation (e.g. female students offered transport in exchange for sex by motorbike taxis and mini-bus operators);
- Instructors favouring female students because of their sex.

[33] Government of Malawi. 2013. Violence against Children and Young Women in Malawi: Findings from a National Survey.

[34] *Ibid.*

[35] *Ibid.*

Emotional violence

- Verbal abuse common among students and instructors towards students;
- Demeaning remarks towards female students' wearing trousers or mini-skirts (from community members);
- Demeaning remarks made by college students towards primary school pupils;
- Demeaning remarks on type of trade studied (e.g. male students being teased for learning fashion and textile design. At one college, a male student dropped out of school because of being mocked by peers);
- Female students are verbally abused by male students or even instructors when they have challenges performing a task in the trades that are male dominated;
- Female students face verbal abuse from male students after terminating a relationship or denying sexual advances;
- Male students seen with female students that are sexual partners or admired by instructors are verbally cautioned by instructors to know their limits in their engagement with the respective female students;
- Husband forcing wife (student) to drop out of college.

Physical violence

- Physical violence among parents/guardians in the home affects students emotionally and psychologically. They do not concentrate in class and it disturbs their studies.

Only 52% of the female students reported to have voluntarily engaged in sex in their first experience. This means that approximately half of the female respondents had been forced or coerced to have sex as their first sexual experience. In contrast, 78% of male respondents stated their first sexual experience was voluntary. A shocking finding from the study is that 66% of the female respondents and 10.6% of male respondents reported to have been forced to have sex, and 12% of the females and 6.5% of the males reported to have been hit by their sexual partner, while 22% of female respondents stated they had received gifts or money in exchange for sex.

**Figure 7: Voluntary first sexual intercourse**

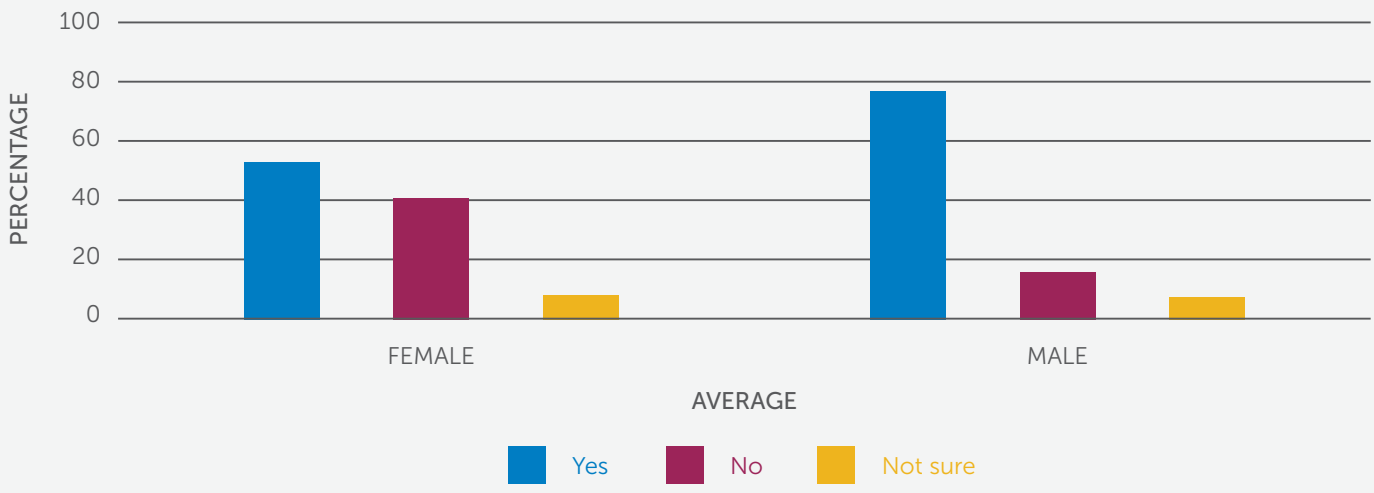


**Table 3: Student's experience of violence (%)**

| Variable | Female | Male |
|---|---|---|
| Hit by a sex partner | 12 | 6.5 |
| Forced to have sex | 66 | 10.6 |
| Received money, gift, alcohol in exchange for sex | 21.9 | 4 |
| Given money, gifts, alcohol in exchange for sex | 6.7 | 13.9 |

### 3.6.2. Abuse of power by instructors for sex with female students

KII and FGD respondents mentioned there have been alleged instances of female students pressured to have sex with instructors to get good grades or stay in college. These allegations were supported by evidence from the anonymous surveys, which indicate that an average of 7% of the female students had been asked for sex by an instructor at their current college, while 11% of female students reported to have been asked for sex by an instructor at their previous college. While 8% reported to have had sex with an instructor at their current college, there was no mention of male students having sex with older women or instructors.

It was noted with concern that none of the respondents acknowledged sexual abuse or rape by a staff member, student, or other individual in both the survey and face-to-face interactions, despite the respondents mentioning instances of forced sex in the survey, FGDs and KIIs. This could be attributed to a misunderstanding of what rape is.

**Table 4: Violence perpetrated by instructors (%)**

| Variable | Female | Male |
|---|---|---|
| Asked for sex by an instructor at current college | 7 | 0 |
| Asked for sex by a teacher at previous school | 11 | 0 |
| Had sex with instructor at current college | 8 | 0 |

### 3.6.3. Gender-based violence prevention services

With regard to GBV interventions, it was established that none of the colleges had deliberate GBV prevention or response services or information targeting TVC students, faculty, and staff. There is no content on GBV as it is related to colleges in curricula for TVCs, orientation checklists for students going for and in attachments, code of conduct for staff, or student social welfare regulations. All this contributes towards students, faculty, and members of staff having minimal knowledge levels of GBV in the context of TVCs, structures and services to support victims or reporting abuse at college and community levels, notably college administration, student unions, VSUs, health facilities, and human rights bodies.

### 3.6.4. Legal action and penalties against perpetrators of violence in technical colleges

Significantly worrying is the fact that no disciplinary actions have been taken against current instructors who are coercing female students to have sex or sexually harassing the female students. There were cases where board members or administrators have talked with perpetrators, however no legal action was taken against the instructor, instructors were not fired or removed from their positions, nor were any written reprimands given.

### 3.6.5. Gender-based violence reporting mechanisms and gender-based violence victim support services in technical and vocational colleges

The study established that the colleges have no formal monitoring and reporting mechanisms of GBV. There is no written policy, specific systems, module, or tools for students and instructors in response to GBV or to support victims. Students are neither formally nor adequately informed of available rules and regulations on reporting mechanisms in the event they experience GBV. The colleges have codes of ethics for instructors and social welfare constitutions for students which loosely mention general cases of indiscipline. Respondents in the KIIs and FGDs mentioned that discipline cases are referred to college administration through a discipline master, matron, or student council. The students, however, expressed reservations about some of the structures, such as the student council, discipline master, matron, patron, and college administration in their capacity to handle cases of GBV, especially when the perpetrator was a college member or staff.

Some of the reasons for not reporting GBV included not being aware that the act perpetrated on them or other students was GBV, not knowing how to react, and not knowing how or where to report a case. In one college, students reported that they would not go to the college management committee to report improper behaviour of instructors as they had never been introduced to the committee, did not know their role, and also felt that it would result in no action as the committee members were friends with the administration and instructors. Students also mentioned that they did not report because they have gotten used to the acts (they find the act normal), or are afraid of being ridiculed, labelled or victimized by the perpetrators, fellow students, or college administration. Female students also stated that they thought administrators would not act on any complaints made against instructors as they were all friends. Male students did not feel free to report sexual harassment perpetrated, especially by female students, for fear of being mocked. The UNFPA mapping study (2016) also found that the majority of students in secular tertiary institutions reported that most girls have acclimatized themselves to the emotional violence that they are regularly subjected to by intoxicated male students to the extent that they do not see any value in reporting such incidences. Both students and college administrators considered VSU support helpful from other experiences outside campus (in their communities).

One VSU support officer mentioned that their unit has handled a few cases involving students in the TVCs, for example, they successfully offered counselling services to a couple where the husband was coaxing the wife to drop out of school because there was no one to look after the house. His complaint was that the wife was always busy with studies and had become rude. Upon counselling both husband and wife, she continued with her studies.

It was established that partnerships between TVCs and organizations working in the field of GBV are generally informal, weak or non-existent. Discussions with college administration and VSU confirmed that there is weak collaboration between colleges. The VSU and college administration should therefore establish a formal working relationship in provision of information, talks, and follow-up of cases.

## 3.7. Safe learning environment and lack of sanitation

An average of 57% of female and 49% of male survey respondents considered their campuses unsafe for both male and female students. During data collection, it was noted that Mzuzu and Chilobwe campuses had poor lighting, while Chongoni campus has no electricity. Toilets for male and female students in all three colleges had no locks. Chilobwe TVC operates in the same compound with a primary school, which presents its own challenges; notably noise from primary school pupils, inadequate classrooms and sanitation facilities (because these are shared), and, cases of college boys teasing primary school female pupils.

Mzuzu Technical College had better sanitation than the other two colleges. Toilets in the teaching blocks and hostels were found to be clean and had sinks and running water. On the other hand, Chilobwe and Chongoni had poor sanitation facilities. The toilet blocks available at Chilobwe had been closed due to poor maintenance of the flushing system, and college and primary school students had to therefore use pit latrines (two for males and two for females). At Chongoni TVC, there are only three pit latrines, which are used by both male and female students, and do not have doors. Neither Chongoni nor Chilobwe campuses had hand washing facilities as there was no access to water and soap.

There were no facilities dedicated for washing, changing, or disposing of sanitary pads, forcing some female students in Chilobwe and Chongoni opting to be absent during menstruation. It was also established that male and female students walk long distances to and from campus, exposing them to risks of accidents, verbal attacks and sexual harassment on their way to campus. A community leader and a member of the college management committee in Chilobwe were of the opinion that female students were particularly at risk to attacks (perpetrated by community members) in private boarding residences and on their way to and from college. Similarly, female students at Chongoni community college felt physically unsafe and were verbally harassed by community members as they travelled from their residence to the college.

## 3.8. Issues related to differing sexual orientation of students

In terms of sexual orientation of students, KII and FGD respondents reported that they were of the opinion that all students were heterosexual and preferred not to say much on the topic. However, in the survey, 6.7% of females and 11% of males reported to be homosexual, whereas 3.7% of the males reported to be bisexual. A KII respondent pointed out that there could be a possibility that others might be homosexual or bisexual but would not dare to come out in the open.

> **I do not even think one would dare thinking of living openly as gay or lesbian. They would never love this place again. They would be the subject of every ridicule. That person would succumb to torture and would possibly wish they dropped out of college.**
>
> **Male respondent, KII**

# 4. Conclusion and recommendations

## 4.1. Summary of issues

The findings discussed above confirm that SRH and GBV services are not available for students in the TVCs.

The study found that:

- SRH and GBV in TVCs are not addressed in relevant national policies, strategic plans, programmes, and curricula.
- Coordination mechanisms for SRH and GBV services in TVCs at national, district, and college levels are weak.
- Students and members of staff in the TVCs have low levels of knowledge on comprehensive SRH issues and GBV, which could lead to low risk perception and inconsistent health seeking behaviours.
- Male and female students in TVCs engage in casual and unprotected sex, serial monogamous relationships, and concurrent multiple partnerships. There are cases of female students engaging in transactional and unprotected sex with married and older men, including instructors. Outcomes of unprotected sex include transmission of HIV and STIs, unplanned pregnancies, and unsafe abortions.
- Students in TVCs face some challenges in accessing SRH services due to social, economic, and physical barriers.
- GBV in TVCs is prevalent, but both female and male students tolerate acts of violence and do not report them to authorities.
- No GBV prevention, response, or victim support system or practices are in place. Perpetrators of violence are not reprimanded or removed from duty and continue to be employed.
- College campuses have poor sanitation and are considered unsafe.

## 4.2. Recommendations

### 4.2.1. Policy review and/or development on sexual and reproductive health and Gender-based violence in technical and vocational colleges

The MoLYSMD should:

- Clarify specific roles and mandate on policy and leadership for SRH and GBV in TVCs at national and district levels. This will enhance coordination and identification of champions and advocates for SRH and GBV. Key institutions that require role clarification are the MoEST, MoLYSMD, TEVETA, National AIDS Commission (NAC), local councils, and National Council for Higher Education;

- Facilitate and oversee the development of a standard policy and code of conduct, as well as guidelines for colleges to address SRH and GBV, including a safe environment for students and staff. The Ministry should revise college codes of ethics to include clauses on sexual harassment experienced by male and female students, staff or instructors, and what repercussions/punishment will follow in the event of such misconduct.
- Ensure inclusion of GBV and SRH in HTEIs in relevant national policies, strategic plans, and action plans for health, HIV and AIDS, education, technical skills development, and gender. SRH and GBV policies and interventions for all institutions should recognize the responsibilities and rights of the male and female students, instructors, and administrators, including the surrounding communities and key partners in the TEVET system.

### 4.2.2. Leadership and coordination of sexual and reproductive health service provision and gender-based violence in technical and vocational colleges

- The MoLYSMD should establish and strengthen coordination mechanisms and leadership structures on SRH and GBV for TVCs. It should revive the inter-ministerial committee on the TEVET system and support it to discuss and receive plans and reports on gender and SRH in the TVCs. The TEVETA should share reports on the implementation of action plans and lessons to the committee on SRH and GBV in TVCs.
- The MoLYSMD should also support the Principals' Forum to provide an opportunity for college principals to discuss and share ideas on issues such as planning, management, lessons, and reporting on SRH and GBV in respective TVCs. The management of the colleges should include SRH and GBV in management meetings, appoint gender-balanced college boards, and strengthen referral systems for SRH and GBV cases. In addition, colleges should strengthen the capacity of male and female students to plan, implement and monitor, coordinate, engage, and advocate for SRH and GBV issues in TVCs through college management boards and student unions.
- Both the TEVETA and TVCs should participate in relevant technical working groups (TWGs) and committees to champion SRH and gender issues for TVCs, as well as improve coordination of TVC among the key players at the national level, including with stakeholders such as the private sector, NAC, Ministry of Health (MoH), NGOs, private sector, district councils, and community leaders.

### 4.2.3. Guideline development and implementation

- Colleges should adapt existing guidelines provided by the MoLYSMD, TEVETA, MOH, and MOEST and develop respective action plans, codes of ethics, and rules and procedures on SRH and GBV. The development of policies and action plans should be participatory and involve students, college boards, staff, management, and faculty to reflect the needs of everyone, as well as the values of the institutions and students. Progress reports on the action plans should be produced and shared on a quarterly basis.

- Colleges should display and disseminate policies and codes of ethics to all students and staff. Topics on GBV and SRH should also be part of the agenda during orientation sessions for new staff and students, management meetings, staff meetings, and student council meetings. Colleges should establish committees to look into matters of SRH, GBV and disciplinary matters as well.
- College principals should organize meetings with the community leadership, community and police VSUs, service providers, and private sector to lobby for support and invite SRH and GBV service providers to offer outreach services and talks at colleges.
- The MoLYSMD should partner with district level implementers, such as district youth officers and NGOs, to offer specific training modules on SRH and GBV, including guidance and counselling.

### 4.2.4. Gender-based violence prevention

- The MoLYSMD should conduct a gender analysis of the TEVET programme and TVCs in order to ascertain the gender gaps and entry points for interventions and mainstreaming of gender in the TVET system. In addition, it should advocate for the active role of gender focal points and HIV coordinators at the MoLYSMD and TEVETA.
- The MoLYSMD should also introduce workplace programmes on GBV and lobby for addressing GBV in the workplace. In addition, it should develop gender-responsive and rights-based training manuals, orientation manuals, codes of ethics, and supervision checklists in line with the results of the gender analysis of the TEVET programme.
- Colleges should:
  - Raise awareness on safety and sanitation on campus and residential areas. They should develop action plans on improving the availability of water, such as having running water in the toilets and managing water and plumbing systems. Sanitation should include construction of adequate toilets with running water commensurate with number of students and building water tanks or reservoirs for use when there is scarcity of water. Adequate pit latrines for alternative use during water shortages should be constructed and be of high quality, such as VIP latrines. Colleges should consider other security measures, such as erecting fences and using solar as a source of lighting to complement power from the Electricity Supply Commission of Malawi (ESCOM) grid;
  - Appoint a committee to address GBV and SRH comprising of students, administration, faculty, and support staff and lobby for appointment of gender balanced college management committees in which females take up leadership positions beyond being Secretary or Committee Member;
  - Identify and eliminate barriers to seeking support for victims of GBV and create an environment where victims feel comfortable disclosing, reporting, and accessing support resources, including providing an anonymous reporting option. Perpetrators of violence must be held accountable – students, instructors or outsiders – and action taken against them. College management should refer victims of GBV to institutions that provide GBV support services, such as community or police VSUs, health facilities, and human rights agencies.

### 4.2.5. Sexual and reproductive health

- Colleges should:
  - Liaise with the district YFHS coordinator to identify health practitioners and CBDAs to visit and offer services at colleges regularly or when need arises;
  - Facilitate promotion and distribution of male and female condoms and training and orientation in condom use and disposal at the colleges.

### 4.2.6. Resource mobilization

- The MoLYSMD should develop an action plan to mobilize technical and financial resources for planning, implementing, monitoring and reporting of SRH and GBV in TVCs. Interventions on SRH and GBV in TVCs should use existing resources and structures to ensure ownership and sustainability of interventions.
- Colleges should establish relationships and linkages with local partners and SRH providers for provision of GBV prevention, expert information, and supplies such as condoms and contraceptives.

### 4.2.7. Curriculum development, teacher training, and learning materials and teaching

- The TEVETA should conduct a rapid training needs assessment to identify knowledge and skills gaps as well as learning needs on SRH and GBV in TVCs for instructors, students, and college staff at personal, classroom, college, and community levels.
- The MoLYSMD, with the support of the TEVETA, should as a matter of urgency include a module on SRH and GBV in the formal harmonized curricula.
- The TEVETA and MoLYSMD should adopt or develop gender-responsive content and integrate SRH, GBV, and HIV in the current training modules, standard guidelines, orientation package, checklists, and toolkits for formal and non-formal programmes for male and female students going for attachments. The Authority should also provide guidelines and information on SRH and GBV to industries and supervisors to protect students attached to workplaces. Existing guidelines and manuals, such as the Dreams Model toolkit (Malawi), UNFPA Comprehensive Sexuality Education, UNFPA and Straight Talk Foundation SRH Training Module for Vocation Training Institute (Uganda), and draft guidance and counselling manuals (Malawi) should be considered for use in the colleges. The content should be relevant and gender aware and adopt good practices on GBV and SRH from the region as well as global guidance from UNESCO, UN Women, UNFPA, Malawi and sub-Saharan Africa. The training should be continuous (not one-off) and address the following, among other topics:
  - Communication, assertiveness and negotiation skills;
  - SRH, HIV prevention, human rights and responsibility;
  - GBV, including situational awareness, verbal response, and self-defence;
  - Risk reduction and awareness of diminished capacity due to alcohol and other drugs;
  - Personal, social, and structural barriers that hamper access to and use of services by youth.

- The MoLYSMD should:
  - Organize courses and equip master trainers (trainer of trainers) and instructors with knowledge, skills and attitude to manage SRH and GBV content in TVCs;
  - Develop key messages on SRH and GBV for use by college students, management and staff to ensure consistent messaging and understanding of issues. The messages should address SRH and GBV risk factors, causes, myths and misconceptions, and where to access SRH and GBV services. Other areas should include rights surrounding SRH and gender, stigma and discrimination, and addressing negative masculinities and attitudes on GBV and cultural norms. Media of communication should be relevant to the needs of college students and should include use of social media and interactive approaches.
  - Appoint male and female instructors to champion and teach SRH, GBV, and CSE in the TVCs. The instructors should be provided with content, packages and manuals and college management should provide moral and psychological support to facilitate their work.
- Colleges should facilitate the:
  - Formation of action groups for male students active in preventing violence against women to act as role models on addressing SRH and GBV in the colleges;
  - Formation and training of gender-balanced college drama and debate clubs and provide toolkits, scripts and themes for discussion.

### 4.2.8. Advocacy and community mobilization

- The MoLYSMD and TEVETA should develop policy briefs and engage development partners, policy-makers, media, human rights and gender advocates, civic leaders, parliamentary committees, district council committees, health/HIV and gender NGOs and TWGs or subgroups. Advocacy topics should include:
  - Recruitment and training of female instructors in non-female traditional trades and college management to increase the number and quality of female instructors and college managers to act as role models and influence attitudes for students in vocational colleges;
  - Affirmative action on the enrolment of female students in non-female traditional trades;
  - Construction of hostels and toilets with running water and electricity installed;
  - Provision of SRH and GBV services and support to victims;
  - Provision of technical and financial resources to TVCs;
  - Engaging males, college boards and community leaders in order to address GBV and poor sanitation and ensure that TVC campuses are safe;
  - Engaging the Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW) and partners to develop a minimum package for interventions on GBV in institutions of higher learning, including TVCs;
  - Engaging faith-based TVCs to ensure students access CSE and SRH services irrespective of principles and values of college leadership and ownership, in line with Malawi's SRHR policy (2009), which stipulates that all people shall have access to health services without distinction of ethnicity, gender, disability, religion, political belief, and geographical location, among others.
  - Taking advantage of opportunities such as social media, the draft HIV Strategy for Institutions of Higher Learning coordinated by NAC, and GBV and SRH initiatives.

### 4.2.9. College inspection, monitoring and reporting

- The MoLYSMD should integrate SRH and GBV in monitoring and reporting mechanisms and tools, including supervision checklists and forms for reporting. The Ministry should ensure that M&E reports on the work of TVCs, and specifically SRH and GBV, feed into the management information system and reports on education, health, HIV, and, gender.

- The TEVETA should consider conducting operational research and situational analyses on GBV- and SRH-related topics in TVCs to generate data and evidence for learning and reprogramming. Colleges would have to ensure that reports are submitted regularly in the required format.

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# Annexes

## ANNEX 1: Terms of reference

### Terms of reference on situational analysis on the status of sexual and reproductive health of students and gender-based violence in vocational colleges in Malawi

## 1. Background

Higher and Tertiary Education Institutions (HTEIs) have a key task of cultivating graduates that will contribute to economic development whilst engaging with the local national, continental and global challenges facing them. Students in HTEIs typically fall between the ages of 18 and 30. Evidence shows that young people in this age category lack adequate sexual and reproductive health (SRH) information, are at elevated risk for unintended pregnancies and for contracting sexually-transmitted infections[37] - and account for a substantial proportion of all new HIV cases world-wide. Due to socioeconomic and biological factors, young women are particularly vulnerable to HIV infection and other negative SRH outcomes, with some estimates indicating that girls aged 15-19 are four times more likely to be infected by HIV than their male age peers.

Universities are home to large numbers of young women and men in the prime of their lives. There is little evidence in Malawi to give a clear picture on what the current situation of SRHR and HIV AIDS is in the tertiary institutions especially as is related to providing quality adolescent sexual and reproductive health information and services. Malawi has increased total enrolment for tertiary levels from late 1990s to date. The total enrolment in 1997 was 3,387 and in 2012 it was 10473 for public and private universities. (Source: Ministry of Education). The period of university admission often represents the first time that many young people experience "real" independence from their parents, guardians, relatives, and teachers who supported and guided them during the early teen years. Many young people are unable to successfully handle the complete independence that comes with university life, making them vulnerable to negative SRH outcomes.[38]

[37] Theresa Nkuo-Akenji et al. 2007. *Knowledge of HIV/AIDS, sexual behaviour and prevalence of sexually transmitted infections among female students of the University of Buea, Cameroon.* African Journal of AIDS Research 6(2): 157-163; W. K. Sekirlme. 2001. Knowledge, attitude and practice about sexually transmitted diseases among university students in Kampala. African Health Sciences 1(1):16-22.

[38] Khamasi, J.W. and Undie, C. 2008. *Teaching human sexuality in higher education: A case from Western Kenya.* In Mairead Dunne (Ed.). Gender, Sexuality and Development: Education and Society in sub-Saharan Africa.

Young women's rights to a safe learning environment, free from sexual and other kinds of violence, and to comprehensive SRH information and services, are currently limited at tertiary level context.[39] Across the region, higher education institutions harbour a large number of young adults at their peak years of sexual activity. As such they are an important target population for HIV and sexuality education which is essential to ensure that they have the knowledge to protect themselves from HIV, other STIs and unintended pregnancies. Universities are also home to young people living with HIV and it is important, to ensure that they are informed about and have access to treatment options and know how to prevent transmission to their partners. A focus on addressing issues which can affect human capital development at tertiary level such as HIV and AIDS and SRH is important for Africa to enjoy the benefits of the projected demographic dividend.

Yet, it is always assumed that because students have reached the tertiary level of education, they have received HIV and sexuality education. Studies on knowledge and attitudes among students show low levels of both HIV and sexuality Education. The low levels of knowledge are also related to negative attitudes towards people living with HIV (UNESCO 2014).

The reality for the region is that too many young people are still growing into adolescence and adulthood without much knowledge about their reproductive health and sexuality and in a context of poor access to sexual and reproductive health services. Higher and Tertiary Education Institutions in sub-Saharan Africa are yet to become a target of comprehensive sexual and reproductive health service provision. Indeed, these institutions are typically viewed as resources for generating research findings, and are less often seen as potential sites for actual interventions.[40] Yet, university campuses provide expansive, eager-to-learn populations of young people, with growing and largely unmet SRH needs, as well as low levels of sexuality education.

Higher and Tertiary Education Institutions also present a valuable space in which important resource to address the sexual and reproductive health and rights of young people exist, and can be harnessed to effect positive change among students and staff alike. The large population that university students represent also creates an enormous opportunity for innovative interventions around sexuality education, and indeed this population also represents an important future part of their societies where many will be in positions to influence and support positive policies and actions. Where interventions have been carried out among tertiary students in the region, rarely have these efforts been rigorously evaluated. They have also often been geared toward a sole intervention (such as peer education), rather than toward a multi-faceted, curriculum-based comprehensive programme.

[39] W. Onyango-Ouma. 2007. S*exuality in the Academia: Challenges and Opportunities.* Sexuality Institute. October 30-November 2, 2007, Mombasa, Kenya.

[40] *Ibid.*

Since 2000 there have been efforts to provide HIV information and services to young people in HTEIs across the region. An example is the work of the Association of African Universities which developed a multidisciplinary HIV and AIDS programme that aimed to scale up the efforts of African Universities to produce AIDS competent graduates. However, studies have shown a mixed picture; indicating that the quality of HIV information provided is variable and the extent of implementation varies. In most cases inclusion of HIV in the curricula has not translated into the curricula being allocated time in the lecture room; nor in lecturers being comfortable to teach it. More importantly the programmes as currently offered are often narrowly focused on HIV prevention to the exclusion of broader sexuality education and access to sexual and reproductive health services.

Evidence shows that good quality, well implemented sexuality education programmes linked to good quality sexual and reproductive health services can result in the following behavioural outcomes amongst young people; reduced number of sexual partners; reduced frequency of sex and unprotected sex; increased condom use; delayed sexual debut.

Consultancy services are being sought to conduct a situation analysis on the status of sexual and reproductive health of students in higher education and tertiary institutions in the SADC region. The situation analysis will inform regional dialogue and advocacy efforts towards improving SRH provision in the tertiary education sector.

## 2. Purpose of the assignment

The consultant will be required to conduct a review of the status of sexuality education and sexual and reproductive health service provision in selected tertiary institutions in the region. The situational analysis is intended to further our understanding of the current and future issues affecting young people's sexual and reproductive health and wellbeing. This assignment is intended to produce a high quality, evidence informed situational analysis report which will provide the basis for dialogue and advocacy with key stakeholders on the importance of prioritizing sexual and reproductive health service provision for the higher education sector. It will also provide useful evidence on young people's health and education needs, and knowledge gaps, which will shed light on and inform pathways for improved Comprehensive Sexuality Education at primary and secondary levels.

In this regard the situation analysis will serve to:

- Profile the demographic characteristics of students attending tertiary education institutions.
- Evaluate the legal and policy frameworks supporting the provision of sexuality education and sexual and reproductive health services in selected tertiary institutions.
- Review the existing programmes on comprehensive sexuality education and HIV and linkages to sexual and reproductive health services and the student perceptions towards these.
- Determine the availability of any subjects covered in the curriculum that address Life Skills Education and content on SRH.

- Review any orientation programmes for students to determine if they address SRH issues/content.
- Analyse the knowledge, attitudes and sexual risk behaviour of students in tertiary education institutions.
- Examine the sexual and reproductive health outcomes of students including HIV and STI prevalence, Pregnancy, Termination of Pregnancy, violence in relationships and marriage.

# 3. Scope of the consultancy

## 3.1 Obtain Ethical Clearance from Malawi Research Council and permission of vocational colleges to conduct study

## 3.2 Desk review

- Profile of tertiary education students
- Demographic Characteristics of tertiary students
- Sexual and Reproductive Health Status of tertiary students
- Key facts and data on the SRH status of young people in tertiary institutions disaggregated by age groups and sex, socio economic status and the implications to education, health and economic development
- Knowledge, Attitudes and Sexual Risk behaviour of students
- Prevalence of HIV, STI, pregnancy and GBV among students
- Response data possibly from existing literature/documents/reports

### 3.2.1 Legal and policy frameworks and strategies governing the provision of sexuality education and the provision of sexual and reproductive services in selected tertiary institutions.

Existing programmes on comprehensive sexuality education and HIV and linkages to sexual and reproductive health services (including examples of any good/promising practises)

Programmes offered and uptake and utilization of services by students

## 3.6 In-depth country studies: Qualitative/quantitative research on the status of young people's sexual and reproductive health and gender-based violence

- Status of SRH programmes offered (sexuality education and SRH services) and uptake and utilization of services by students
- Knowledge, attitudes and sexual risk behaviour of students

- Prevalence of HIV, STI, pregnancy and GBV
- Collection of quantitative data from health service providers and police/security forces and victim support units and CSOs.

Perceptions of key stakeholders on the situation of young people in HTEI and measures in place to address some of the challenges faced. Interviews will include but will not be limited to; Department of Higher Education in the Ministry of Education, Department of TEVET in the Ministry of Labour, Sports, Youth and Manpower, TEVETA'; Ministry of Health, College Management; Student Health Services (if on campus, closest health facilities if off campus); local police unit including the Victim Support Unit; Student Council members, Selected faculty members (including those teaching Life Skills, Orientation; ; National AIDS Council; UN and Development Partners (NGOs) working with colleges. A draft list of suggested interviewees will be provided to the consultant. A minimum of 40 students (20 women and 20 men) will be interviewed in each of the two colleges.

The final selection of 2 colleges will be done in collaboration with UNESCO. The suggested colleges are Mzuzu technical college and Mponela community technical college.

# 4 Development of final report with key advocacy messages and recommendations for the TEVET sector

The consultants will synthesize the findings into a concise report (not more than 30 pages) outlining the status of sexual and reproductive health of young people in tertiary institutions in the selected institutions. They will identify gaps, challenges, and opportunities in current SRH programmes, including HIV and AIDS interventions in HTEIs and make recommendations for priority actions to enhance HTEIs capacity to effectively implement an appropriate response.

Finally, the consultancy will identify best practice or promising models (programmes, strategies & institutional arrangements) as measured against current international, regional and national evidence of what works for young people in tertiary institutions, that could be adapted and replicated for implementation across the higher and tertiary education institutions.

# 5. Focus of the assignment

The focus of this assignment is on the TEVET system and TVCs. The purpose is to collect quantitative and qualitative data and not only provide a literature review. It will complement the regional study. The regional study includes a desk review of literature collected from all SADC countries and in-depth quantitative and qualitative data from universities in Tanzania and Zimbabwe.

# 6. Deliverables

- The consultant is expected to produce the following deliverables:
  - Inception Report
  - Situation Analysis Report with annexes indicating list of people interviewed and contact information
  - PowerPoint presentation summarizing the Status Report
  - All data from findings

# 7. Timeline and duration of consultancy

The consultant will be hired during the period April - May 2017. The schedule below sets out the deliverable and indicative dates. Deadlines for deliverable will be set in discussion with the consultant.

# 8. Profile of consultant

- The consultant is expected to produce the following deliverables:
  - Inception Report
  - Situation Analysis Report with annexes indicating list of people interviewed and contact information
  - PowerPoint presentation summarizing the Status Report
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# 7. Timeline and duration of consultancy

The consultant will be hired during the period April - May 2017. The schedule below sets out the deliverable and indicative dates. Deadlines for deliverable will be set in discussion with the consultant.

# ANNEX 2: Data collection tools

## A. Survey questionnaire - Malawi

## Situational analysis on the status of sexual and reproductive health of students and gender-based violence in technical and vocational colleges in malawi

### Purpose

The purpose of this survey is to better understand the situation of college students with regard to their sexual and reproductive health (SRH) and the extent of violence experienced by students.

### Confidentiality

This survey is anonymous. We will not use your name at any time in the report. DO NOT write your name on this paper.

## Section A: Demographic questions

1. Which month and year did you start studying at this technical college?

   Month
   Year

2. Are you studying full or part time?

   a. Full time
   b. Part time

3. What is your date of birth

   [dd/mm/yyyy]

4. For how many years have you been studying at college?

5. Have you completed an attachment as part of your college training?

6. What is your biological sex?

   a. Female
   b. Male
   c. Intersex (I have both male and female biological sexual characteristics)

7. What is your gender?

   a. Female
   b. Male
   c. Transgender (my gender identity is not the same as my biological sex)
   d. Non binary (I do not wish to identify as male or female)

8. How would you describe your sexual orientation?

   a. Heterosexual
   b. Homosexual/gay/lesbian
   c. Bisexual
   d. Other

9. Are you currently employed?

    a. Yes
    b. No

10. If yes

    a. Full time
    b. Part time

For women:

11. How many times have you been pregnant?

    0, 1, 2, 3, 4, >4

12. How many children have you given birth to?

    0, 1, 2, 3, 4, >4

For men and women:

13. How many biological children do you have that are alive today?

    0, 1, 2, 3, 4, >4

14. What is your marital/relationship status?

    a. Single
    b. Married
    c. Cohabiting (living with partner as if married)
    d. Divorced
    e. Widowed
    f. Separated
    g. None of the above

15. Where do you live whilst at college?

    a. College residence/housing
    b. Off campus (in accommodation just for myself)
    c. Off campus (in shared accommodation)
    d. I live with my parents
    e. I live with my spouse/partner
    f. Other

16. What is the highest level of education in your biological family?

    a. Primary school only
    b. Did not finish secondary/high school
    c. Finished secondary/high school
    d. Some college education
    e. Some university education
    f. Undergraduate university degree
    g. Postgraduate university degree
    h. I don't know

17. What is your current household income per year? (To convert)

    a. <MK 2,000,000
    b. MK 3,000,000 - 5,000,000
    c. MK 6,000,000 - 10,000,000
    d. MK 11,000,000 - 20,000,000
    e. > MK20,000,000

## Section B: Sexual behaviour

The next questions are about your sexual behaviour. Some of the questions ask for sensitive information. Please be assured that all your answers are confidential and anonymous and cannot be linked back to you in any way. You do not have to answer any questions you are uncomfortable with in this section.

18. Do you have close friendships with people of the opposite sex?

    a. Yes
    b. No

19. Have you ever had sexual intercourse (including vaginal sex/intercourse, anal sex/intercourse or oral sex)?

    a. Yes – if yes continue to the next question
    b. No – if no please continue to section C

20. At what age did you first have sex/sexual intercourse?

    a. Younger than 10
    b. 10-15
    c. 16-20
    d. 21-25
    e. Older than 26

21. Was your first sexual intercourse voluntary and consensual (with your agreement)?

    a. Yes
    b. No
    c. Don't know

22. Did you use a condom the first time you had sexual intercourse?

    a. Yes
    b. No
    c. Don't know

23. In your lifetime, how many people have you had sex with?

    0, 1, 2, 3, 4, 5, >5

24. Please indicate below one or more types of sex you regularly engage in (multiple response option – you can circle more than one response)

    a. Vaginal sex
    b. Anal sex
    c. Oral sex

25. How often do you have sex?

    a. Every day
    b. Several times a week
    c. Once a week
    d. Once a month
    e. Less than once a month

26. Are you currently in a relationship with a primary partner?

    a. Yes
    b. No

27. Do you always have sex only with your primary partner?

    a. Yes
    b. No

28. Do you have a non-steady/casual partner you have sex with?

    a. Yes
    b. No

29. Did you use a condom the last time you had sex with any partner?

    a. Yes
    b. No

30. How often do you use condoms when you have sex?

    a. Always
    b. Most of the time
    c. Sometimes
    d. Rarely
    e. Never

31. Has anyone ever given you money, gifts, drugs, alcohol or a place to stay in exchange for sex?

    a. Yes
    b. No

32. Have you ever given anyone money, gifts, drugs or a place to stay in order to have sex with them?

    a. Yes
    b. No

33. Has a sex partner ever hit you?

    a. Yes
    b. No

34. Has someone ever forced you to have sex when you did not want to?

    a. Yes
    b. No
    c. Don't know

35. Have you ever forced someone to have sex when they did not want to?

    a. Yes
    b. No
    c. Don't know

36. Has an instructor/teacher ever asked you to have sex (at any of your previous schools)?

    a. Yes
    b. No
    c. Don't know

37. Has an instructor/teacher or administrator in your current college ever asked you to have sex?

    a. Yes
    b. No
    c. Don't know

38. Have you had sex with an instructor/teacher or administrator in your current college?

    a. Yes
    b. No

39. Would you be afraid to ask a sexual partner to use condoms?

    a. Yes
    b. No
    c. Don't know

40. How many times have you had sex without using a condom in the past 12 months?

    a. 0
    b. 1-3
    c. 4-6
    d. More than 7

41. What type or types of contraception are you currently using, if any?

    - None
    - Injectables
    - Oral contraceptive pills
    - Condom (male or female) only
    - Condom with another contraceptive method
    - Intrauterine device (IUD)
    - Implant
    - Rhythm/natural methods

## Section C: Sexual health

42. Have you ever been treated for a sexually transmitted infection (STI) e.g. chlamydia, gonorrhoea, genital warts, hepatitis C?

    a. Yes
    b. No

43. Have you ever been tested for HIV?

    a. Yes
    b. No

44. Have you ever accessed an HIV testing and counselling service at your college?

    a. Yes
    b. No
    c. I don't know if the service is offered at my college

For Women (43-47):

45. If you are female, have you ever experienced an unintended/unplanned pregnancy?

    a. Yes
    b. No

46. Have you ever terminated an unintended/unplanned pregnancy?

    a. Yes
    b. No

47. Which of the following statements is true for you?

    a. I have access to free abortion services
    b. I only have access to abortion services that charge
    c. I don't have any access to abortion services
    d. I don't know where to go if I wanted to terminate my pregnancy
    e. I have never needed to access abortion services

48. Which of the following statements is true for you?

    a. I have access to contraception which is provided free of charge
    b. I only have access to contraception which I have to purchase
    c. I don't have any access to contraceptives
    d. I don't know where to access contraceptives
    e. I have never needed to access contraceptive services

49. Have you ever accessed contraceptive services on campus?

    a. Yes
    b. No
    c. I don't know if there is a contraceptive service on campus

For men and women:

50. Have you had education or training on how to have healthy relationships including how to communicate in a relationship, different ways to express love, how to be respectful?

    a. Yes
    b. No
    c. If yes, where did you have this training?

51. Have you been exposed to any sexual health information/education/campaigns whilst on campus?

    a. Yes
    b. No
    c. I'm not sure

52. Have you consulted the health services on campus about a sexual health issue?

    a. Yes
    b. No
    c. I don't know if there is a health service on campus

53. If you have consulted the health services about a sexual health issue, how helpful was their response?

    a. Very helpful
    b. Rather helpful
    c. Rather unhelpful

# B. Focus group discussion interview guide – Malawi

## Situational analysis on the status of sexual and reproductive health of students and gender-based violence in technical and vocational colleges in Malawi

| | Main question | Probe |
|---|---|---|
| 1 | When we talk about sexual and reproductive health, what do you understand this term to mean? | • What health concerns are linked to sexual health?<br>• What health concerns are linked to reproductive health?<br>• What are some examples of SRH issues?<br>• What are some things that can affect our SRH? |
| **Before moving onto next questions, the interviewer needs to ensure that issues related to HIV, pregnancy, STIs, GBV, risky sexual behaviour are raised in some form in the discussion** | | |
| 2 | We have identified a number of important SRH issues. We have identified HIV, pregnancy, STIs, GBV, risky sexual behaviour. Which of these SRH issues do you see as particular problems affecting students? | • Which are the most common SRH issues that are heard about or seen amongst your peers?<br>• How do you think these SRH issues can be supported best (Interviewer to explore information versus service needs in this discussion)?<br>• Are there any specific groups of students who you view as particularly vulnerable to poor SRH outcomes? Who are these students and why do you think this may be the case? |
| 3 | What do you think should be the role of your college in providing students with SRH information and service support? | • Is support needed and is the college best placed to provide this support?<br>• How would you like to see your college interacting with students on their SRH issues and needs?<br>• How would students like to see campus services structured?<br>• What are some of the platforms that students would like to see in order to learn more about SRH issues (e.g. curriculum, edutainment, mobile health messages, and campaigns)? |
| 4 | What is your college's current level of support in providing students with SRH information and services? | • Are there any curricula/courses provided to students to increase their knowledge of SRH issues, including HIV?<br>• Are you aware of any campaigns that have been run on campus?<br>• What kind of services are needed by the students to support their SRH (e.g. contraceptive, ARVs, HCT, STI, cervical cancer/HPV screening)?<br>• What have been student experiences with accessing these services?<br>• What are the barriers to students accessing to SRH services (affordability, perceptions of quality, availability, staffing)?<br>• How would students like to see campus services structured? |

| | | |
|---|---|---|
| **5** | Where do students prefer to access clinic services for their SRH needs? | • Who are the providers? What services are provided? Where are these services located?<br>• Why are these services preferred over other available services? |
| **6** | I would like to take a bit of time to focus on a few very specific SRHR issues. The first issues relates to unintended or unplanned pregnancies. Can you tell me whether unintended pregnancies is an issue of concern on campus? | • Why is it an issue of concern?<br>• What is the nature of the problem? |
| **7** | Thank you, now I would like to turn to the issue of GBV. To what extent do you view your campus as a safe space for students where everyone is free from all types of violence including physical or sexual violence or sexual harassment? | • Is violence a problem on your campus, and particularly sexual violence or harassment? How does this manifest on campus?<br>• Who are the perpetrators of the sexual harassment?<br>• Which students experience sexual harassment?<br>• What is the nature of the sexual harassment/violence? |
| **8** | What are the policy responses and monitoring mechanisms to sexual harassment/violence? | • What are the reporting mechanisms and where are reports/ complaints lodged? How are complaints followed up?<br>• What services are available for survivors of violence?<br>• What is the perception of these services? |
| **9** | Thank you again. Now I would like to turn another specific SRHR issue. This one relates to gender identity and sexual orientation of students. When I talk about sexual orientation, I am referring to a person's sexual identity and the gender to which they are attracted – this could be a man is attracted to a man, or a woman to a woman, or a man or woman being attracted to both sexes. Can you tell me a bit about whether there are any issues related differing sexual orientations of students? | • What are the specific issues?<br>• What are the challenges? |
| **10** | What are your views on the peer education programme at your campus? | • Are students aware of a peer education programme?<br>• What have been student experiences with the programme?<br>• Is there a perceived role for the programme and does it meet student expectation and need?<br>• Do students have any suggestions to improve the programme? |
| **11** | Before we end this session, is there anything else that you would like to tell raise related to what we have been discussing? | |
| **This is the end of our discussion. Thank you for your time.** | | |

# C. Situational analysis on the status of sexual and reproductive health of students and gender-based violence in technical and vocational colleges in malawi

## Key informant interview guide – national and district level stakeholders

| | Main question | Probe |
|---|---|---|
| 1 | What is your opinion concerning the current SRH services for students in technical and vocational colleges? | a. What services are currently offered and who is offering them?<br>b. Where are the gaps?<br>c. What do you think is working and what is not working currently?<br>d. What are the most common SRHR issues amongst these students?<br>e. How do you think SRH issues can be best supported and by who?<br>f. Are there any specific groups of students who you view as particularly vulnerable to poor SRH outcomes?<br>g. Who are these students and why do you think this may be the case? |
| 2 | Is there a policy or guideline which discusses the provision of a safe learning environment at technical colleges? | a. Does this state specifically prevention of school related gender-based violence?<br>b. Does the policy discuss the provision of sexual and reproductive health services at the college? |
| 3 | What are the roles of stakeholders in addressing SRH issues for technical and vocational college students? | a. Role of respondent's institution<br>b. Role of other players<br>c. What are current challenges?<br>d. What are current strengths and opportunities? |
| 4 | In your view what are the GBV issues that occur in technical and vocational colleges? | a. What is the situation like currently?<br>b. What are the most common GBV issues?<br>c. Are there any groups of students that you consider particularly vulnerable to GBV?<br>d. What services are there for GBV victims in technical and vocational colleges?<br>e. What gaps are there as far as responding to these issues is concerned<br>f. What are the strengths and weaknesses of the current response to GBV in these institutions? |
| 5 | What can you say about the coordination of SRH and GBV services in technical and vocational colleges by various stakeholders and the institutions themselves? | |
| 6 | What are your views on the SRH/GBV education programmes available in technical and vocational Colleges? | How can they be strengthened? |
| 7 | What are your views on the SRH/GBV education policies available in technical and vocational Colleges? | How can they be strengthened? |
| 8 | What kind of interventions would you propose for students in relation to what we have discussed today? | |
| 9 | Is there anything concerning SRHR and GBV in technical and vocational colleges which I haven't asked that you would like to tell me? | |
| **Thank you for your time!** | | |

# D. Situational analysis on the status of sexual and reproductive health of students and gender-based violence in technical and vocational colleges in Malawi

## Key informant interview guide – board members, faculty members, administrators and matrons

| | Main question | Probe |
|---|---|---|
| 1 | What is your opinion with regards to SRH services for students at this college? | • What SRH/GBV/HIV services does the college offer?<br>• Who is responsible for offering these services?<br>• How efficient are these services? |
| 2 | What do you think about sexual and reproductive health of students at your college? | • What is the current situation as far as students SRH is concerned?<br>• What are the most common SRH/HIV/GBV issues amongst these students?<br>• How do you think these SRH issues can be best supported? |
| 3 | What are the most common SRH challenges that students face at this College? | • Are there any specific groups of students who you view as particularly vulnerable to poor SRH outcomes?<br>• Who are these students and why do you think this may be the case? |
| 4 | What do you think are the roles of your college and stakeholders in addressing SRH/HIV/GBV issues for technical and vocational college students? | • Roles of your college, relevant ministries, development partners, District Councils, Community Leaders, NGOs |
| 5 | What can you say about the extent of GBV at this college? | • To what extent is this an issue at this college?<br>• What type of violence occurs in this college?<br>• Does the college provide any form of support to victims?<br>• What gaps are there as far as responding to these issues is concerned<br>• What is working and what are the opportunities? |
| 6 | What can you say about the coordination of SRH and GBV services between technical and vocational colleges and various stakeholders and the institutions themselves? | |
| 7 | What are your views on SRH/GBV information and services provided to students? | • Are there any curricula/courses provided to students to increase their knowledge of SRH/HIV/GBV?<br>• What do you think is the colleges' current level of support in providing students with SRH information and services?<br>• Is the college best placed to provide support?<br>• Are you aware of any campaigns that have been run on campus?<br>• What kind of services are needed by the students to support their SRH (e.g. contraceptive, ARV, HCT, STI, cervical cancer/HPV screening)?<br>• What kind of services are needed by students to support them when abused?<br>• What are your proposals for improvement in provision of these services? |

| | | |
|---|---|---|
| **8** | What can you say about students' ability to access clinical services on an SRH issue (perceived stigma, attitude, low health seeking behaviours) | • Which are the health facilities where students from this institution normally seek SRH/HIV/FP services? In your own view, why do you think students seek services from these facilities which you have mentioned?<br>• How best would SRH and GBV issues be best structured to meet the needs of students in these colleges |
| **9** | In your opinion, where do students prefer to access clinical services for their SRH needs and to report GBV? Why is this the case? | |
| **10** | What are the policy responses and monitoring mechanisms to sexual harassment/violence? | • Are issues of SRH/HIV/FP/GBV reflected in any of the existing policies or guidelines of this institution? If yes, what are the specific provisions in these policies and guidelines? |
| **11** | What are your views on the peer education programmes available in technical and vocational Colleges? | • How effective are these? |
| **12** | What kind of interventions would you propose for students in relation to what we have discussed today? | |
| **13** | 13. Is there anything concerning SRHR and GBV in technical and vocational colleges which I haven't asked that you would like to tell me? | |
| **Thank you for your time!** | | |

# E. Situational analysis on the status of sexual and reproductive health of students and gender-based violence in technical and vocational colleges in Malawi

## Key informant interview guide – health workers and victims support unit

| | Main question | Probe |
|---|---|---|
| 1 | 1What SRH/HIV/GBV services do you offer to students in technical and vocational colleges? | a. What is available currently and who is responsible?<br>b. How efficient is the programming and support for students?<br>c. Where are the gaps?<br>d. What is working and how can we build on it? |
| 2 | What do you think about sexual and reproductive health of students in technical and vocational colleges? | a. What are the most common SRH/HIV/GBV issues amongst these students?<br>b. How do you think these SRH issues can be supported best?<br>c. Are there any specific groups of students who you view as particularly vulnerable to poor SRH outcomes? Who are these students and why do you think this may be the case? |
| 3 | Which organizations are working with the institution in the area of SRH/FP/HIV/GBV? Which particular interventions are undertaken by each organization? | |
| 4 | *To health service providers only*. What can you say about the capacity of your health services available on and around campuses? What do you think are the current challenges and gaps in reaching to these students with best service? | |
| 5 | *Does your clinic offer abortion facilities?* If not, where are these services offered? | |
| 6 | *To VSU only*. What can you say about the capacity of your services available on and around campuses? | |
| 7 | What do you think are the current challenges and gaps in reaching to these students with best service? | |
| 8 | What do you think about the role of other stakeholders in addressing SRH/HIV/GBV issues for technical and vocational college students? | a. Type of service?<br>b. Role and mandate?<br>c. What are current strengths and opportunities? |
| 9 | What role do you think you ought to play to support these students with SRH information and service support as well as GBV? | a. What do you think is the colleges' current level of support in providing students with SRH information and services?<br>b. Is the college best placed to provide this support?<br>c. Are there any curricula/courses provided to students to increase their knowledge of SRH issues, including HIV and GBV?<br>d. Are you aware of any campaigns that have been run on campus?<br>e. What kind of services are needed by the students to support their SRH (e.g. contraceptive, ARV, HCT, STI, cervical cancer/HPV screening)? |
| 10 | What can you say about the coordination of SRH and GBV services in Technical and Vocational colleges by various stakeholders and institutions themselves? | |

| | | |
|---|---|---|
| 11 | What can you say about students' ability to access clinical services on an SRH issue (perceived stigma, attitude, low health seeking behaviours) | a. How best would SRH and GBV issues be best structured to meet the needs of students in these colleges? |
| 12 | Where do students prefer to access clinic services for their SRH needs and to report GBV? | |
| 13 | What are the policy responses and monitoring mechanisms to SRH and GBV? | |
| 14 | What are your views on the information programmes available in technical and vocational Colleges? | a. How effective are these? |
| 15 | What kind of interventions would you propose for students in relation to what we have discussed today? | |
| **Interviewer should request data on sex, number and type of cases treated/supported; type of support provided and outcome.** | | |
| **At health clinic – interview should note the types of contraceptives and cost for each kind** | | |
| **Thank you for your time!** | | |

# ANNEX 3: Consent form

United Nations
Educational, Scientific and
Cultural Organization

UNESCO is undertaking a situational analysis on the status of sexual and reproductive health of students and the extent of gender-based violence in technical colleges in Malawi.

We appreciate your participation in this study. Please note that all participation in the survey and focus group discussion is anonymous.

☐ I agree to participate in this study
☐ I am 18 years or older

Name:
Signature:
Age:

# ANNEX 4: Number and sex of academic and administrative staff

| College | Male | Female | Total |
|---|---|---|---|
| **Academic** | | | |
| Chilobwe | 6 | 2 | 8* |
| Chongoni | 6 | 0 | 6 |
| Mzuzu | 25 | 3 | 28 |
| **College management (Principal)** | | | |
| Chilobwe | 1 | 0 | 1 |
| Chongoni | 1 | 0 | 1 |
| Mzuzu | 1 | 0 | 1 |
| **College management (Vice principal)** | | | |
| Chilobwe | 0 | 1 | 1 |
| Chongoni | 0 | 0 | 0 |
| Mzuzu | 0 | 0 | 0 |
| **Administrative and support** | | | |
| Chilobwe | 5 | 1 | 6 |
| Chongoni | 5 | 1 | 6 |
| Mzuzu | 32 | 29 | 61 |
| **College management committee** | | | |
| Chilobwe | 5 | 1 | 6 |
| Chongoni | 5 | 1 | 6 |
| Mzuzu | 5 | 4 | 9 |
| ***In Chilobwe Community Technical College, the principal and vice principal are also academic staff** | | | |

# ANNEX 5: List of organizations consulted

Chilobwe Community Technical College
Chilobwe Community Technical College Board
Chilobwe Community
Chilobwe Police Victims Support Unit
Blantyre District Labour Office
Zingwangwa Health Centre
Mzuzu Technical College
Mzuzu Youth Friendly Health Service Unit
Zolozolo Police Office, Mzuzu
Ungweru youth Organization, Mzuzu
Chongoni Community Technical College
Chongoni Community Technical College Board
Ministry of Labour, Youth, Sports and Manpower Development
TEVETA
Ministry of Health
Ministry of Education, Science and Technology
Ministry of Gender, Children, Disability and Social Welfare
National AIDS Commission
National Youth Council
UNFPA

# ANNEX 6: List of participating organizations at validation meeting

Ministry of Education Science and Technology, School Health Nutrition Unit
Ministry of Labour, Youth sports and Manpower Development
Chilobwe Community College, Blantyre
Southern Africa AIDS Trust (Malawi)
TEVETA
UNFPA
UN Women
UNAIDS
UNESCO
UNESCO, STEP

Funded by the EU and implemented by UNESCO in collaboration with the Government of Malawi, the Skills and Technical Education Programme (STEP) is dedicated to reinforcing Technical, Entrepreneurial and Vocational Education and Training (TEVET) in Malawi.

The programme will run from 2016-2020 and aims to improve TEVET at post-secondary level with a focus on equal access to enrolment, with particular emphasis on female learners; improving quality in the sector; and the establishment of clear governance structures.

The STEP Research Series presents the highlights of the research undertaken by the programme.

The situational analysis on the status of sexual and reproductive health of students and gender-based violence in technical and vocational colleges in Malawi is the second report in the STEP Research Series.

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