EXAMINING STAKEHOLDERS' VALUES AND ATTITUDES TOWARDS CONDOM DISTRIBUTION TO ADOLESCENT LEARNERS IN SECONDARY SCHOOL IN NKHOTAKOTA, MALAWI

M.A.(APPLIED ETHICS) THESIS

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UNIVERSITY OF MALAWI

CHANCELLOR COLLEGE

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M.A.(APPLIED ETHICS) THESIS

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DECLARATION

This thesis is my own original work and it has not been submitted to any other institution for similar purposes. Acknowledgements have been duly made where other people's work have been used. I bear the responsibility for the contents of this paper.

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Date

CERTIFICATE OF APPROVAL

The undersigned certify that this thesis represents the student's own work and effort and has been submitted with our approval.

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Head of Department

DEDICATION

I dedicate this work to God who has been with me through thick and thin. I also dedicate this thesis to my grandparents for being there for me since I was born to this level of intellectual achievement.

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Firstly, I would like to give honour to the almighty God for giving me the grace to walk through this academic life. If it were not for your will God, all this toil would be in vain. I would like also to extend my sincere gratitude to my supervisor Dr. Vincent Jumbe for his constructive pieces of advice and corrections. I owe you a debt that I cannot repay, and may the good Lord continue blessing you. I extend my appreciation also to Dr. Ndasauka, the head of Philosophy Department, for his insights that have helped to shape my work. Most importantly, I thank the entire Department of Philosophy for grooming me to this far.

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ABSTRACT

The study examined values and attitudes towards condom distribution to adolescent learners in secondary school in Nkhotakota, Malawi. The problem which raised this debate was that the Ministry of Health (MoH) and some NGOs were promoting condom distribution in secondary schools. The reason for promoting condoms was that adolescents would be prevented from contracting or transmitting HIV and STIs and unplanned pregnancies. This, however, was not welcomed by other stakeholders especially the Ministry of Education Science and Technology (MoEST) and the religious community claiming that distributing condoms in schools has the potential to increase sexual practices among students.

A cross sectional mixed methods survey was designed to investigate the values and attitudes of the stakeholders towards condom use and distribution among learners. Eight key informants and 119 adolescent learners aged between 15 and 19 were recruited as study participants. The study established that most adolescents have positive values and attitudes towards condom distribution and use in school. However, the study also found out that other stakeholders like religious leaders and key informants from the education sector had values and attitudes which did not accept condom distribution to adolescents in secondary schools. For the values and attitudes from adolescent leaners, utilitarian theory was used in an ethical examination. Conflicting values and attitudes of different stakeholders were examined using common morality and beneficence ethical principle.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
DHO	District Hospital
FOCCAD	Foundation for Community Capacity Development
HIV	Human Immune-deficiency Virus
MDI	In depth interviews
MDP	Malawi Demographic Profile
MoE	Ministry of Education
MoH	Ministry of Health
MPHIA	Malawi Population-Based HIV Impact Assessment
WHO	World Health Organization
UNAIDS	United Nations Program on HIV and AIDS
UNCEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Nations Fund for Nations
USA	United States of America
YMSMs	Young Men Sleeping with Same Male Sex

CHAPTER 1

GENERAL INTRODUCTION

1.1 Introduction

This chapter gives an overview of condom distribution to adolescent learners. The chapter begins with the background information on adolescent sexual and reproductive health issues and explains the main concepts employed in this study. Later, the chapter explains the statement of the problem, the objectives, research questions and the significance of the study.

1.2 Background

The term 'adolescence' is defined as the period between 10 and 19 years of age. It is a continuum of physical, cognitive, behavioral and psychological change that is characterised by increasing levels of individual autonomy, a growing sense of identity and self-esteem and progressive independence (United Nations, 2011). The term youth is understood as all persons from age 10 to 35 years regardless of their sex, race, education, culture and religion, economic, marital and physical status (Ministry of Youth and Sports, 2013). UNFPA, WHO, UNICEF define youth as people of ages falling within 15 to 24 years (United Nations, 2012).

Condoms have been scientifically proven that they prevent HIV, STIs and unwanted pregnancies with 80% to 85% effectiveness and up to 95% with constant and correct use (UNAIDS, 2016). Condom distribution programs in schools have been promoted as a promising approach for increasing condom use among students, for reducing the risk of infections from the human immune deficiency virus and other sexually transmitted

diseases and for preventing unintended pregnancy to promote sexual and reproductive health among adolescents (Brakma et al. 2017).

Thirteen billion condoms are needed per year to minimise the risk of contracting HIV, STIs and getting unintended pregnancies but only 4.4 billion are accessed globally (Health Policy Project, 2017). Therefore, the least condom consumption rate leaves a burden on global health. Globally, curable STIs new infections were estimated at 499 million yearly and particularly higher in U.S.A than in other developed nations but heavily burdened on developing or low income nations (WHO, 2011). As a global phenomenon, STIs are costly and dangerous among adolescents with U.S.A reporting over 9 million STIs yearly, and one in every four young women aged 15 to 19 has STIs.

People of ages between 0 and 24 constitute almost 67% of the entire population of Malawi, adolescents inclusive (Central Intelligence Agency, 2018). Approximately six in ten of 15 to 19 years of age have ever had sex; nearly eight in ten have had sex by age 20 (Health Policy Project, 2017)). This therefore shows that sexuality of adolescents is equally an important aspect of health which should be given considerable attention to avoid greater harm.

The Malawi Population HIV Impact Assessment (MPHIA) highlights high HIV incidences among adolescent girls and young women (AGYW) in Malawi with 8 times higher among fem ales aged 15-24 than males (Ministry of Health, 2017) According to Strategic Assessment of Unsafe Abortion in Malawi, teenage pregnancies among adolescents aged 15-19 constitute 20% to 30% maternal deaths. (Jackson, Johnson, Gebreselassie, Kangaude, and Mhango, 2015). One of the strategies used to control such health burdens is condom use. According to Cisek, and Khomani (2018), condoms were distributed at hospitals, offices, community based organizations and other points but not in secondary schools. It has to be noted that this Condom Distribution Assessment report is not in line with the National Condom Strategy of Malawi (2015-2020) which intends to increase the demand for condom use, raise awareness about HIV, STI and family planning and make condoms accessible to adult ages of 15 to 49 by 2020 (Ministry of

Health, 2017). As such, the Ministry of Health through its National Condom Strategy faces conflicts with the values of the Ministry of Education and other stakeholders such as religious and cultural groupings.

1.3 Conceptual framework

The study used the adapted socio ecological model originally designed by Mc Leroy Bibeau, Steckler and Glanz (1988) and also used by Ranjeeta, Jahan and Baatsen (2016) which describes factors influencing modern contraceptives use among adolescents in Nepal. It provides an ideal situation for understanding the interactive effects of personal and environmental factors that determine contraceptive use. In line with this study, these interactive effects were focused on condom use among adolescents in schools. According to Ranjeeta, Jahan and Baatsen (2016), this socio ecological model is widely used to identify the factors that determine the health behaviour and also to identify the effective interventions for health promotion.

This socio ecological model assumes that there are five key determinants that influence adolescent sexual behaviour in response to contraceptive use. These determinants include individual, interpersonal, organizational, community and policy influences.

Individual level: This is the innermost sphere in the concentric sphere which includes factors like education, knowledge, perception of adolescents, their attitude, economic status, personality traits and behaviour towards sexual activity which influence their decision on the use of contraception.

Interpersonal level: This describes the positive and negative influence of family members, peers and intimate partners in influencing the adolescents' behaviour in condom use.

Organizational level: This includes the organizational characteristics like availability of adolescent services and contraceptives, accessibility and utilization, and formal education which support or constrain the adolescent behaviour.

Community level: This analyses informal networks like gender, societal norms, cultural values and religion which influence the behaviour of adolescents on the use of contraceptives.

Policy level: This describes the national policies and laws promoting adolescent sexual health.

This conceptual framework was used to provide a road map for the literature which was reviewed in relation to factors relating to condom use and sexual behaviour among adolescents. This also helped in identifying variables to be included on the social demographic characteristics and questions relating to values and attitudes of the participants on condom use.

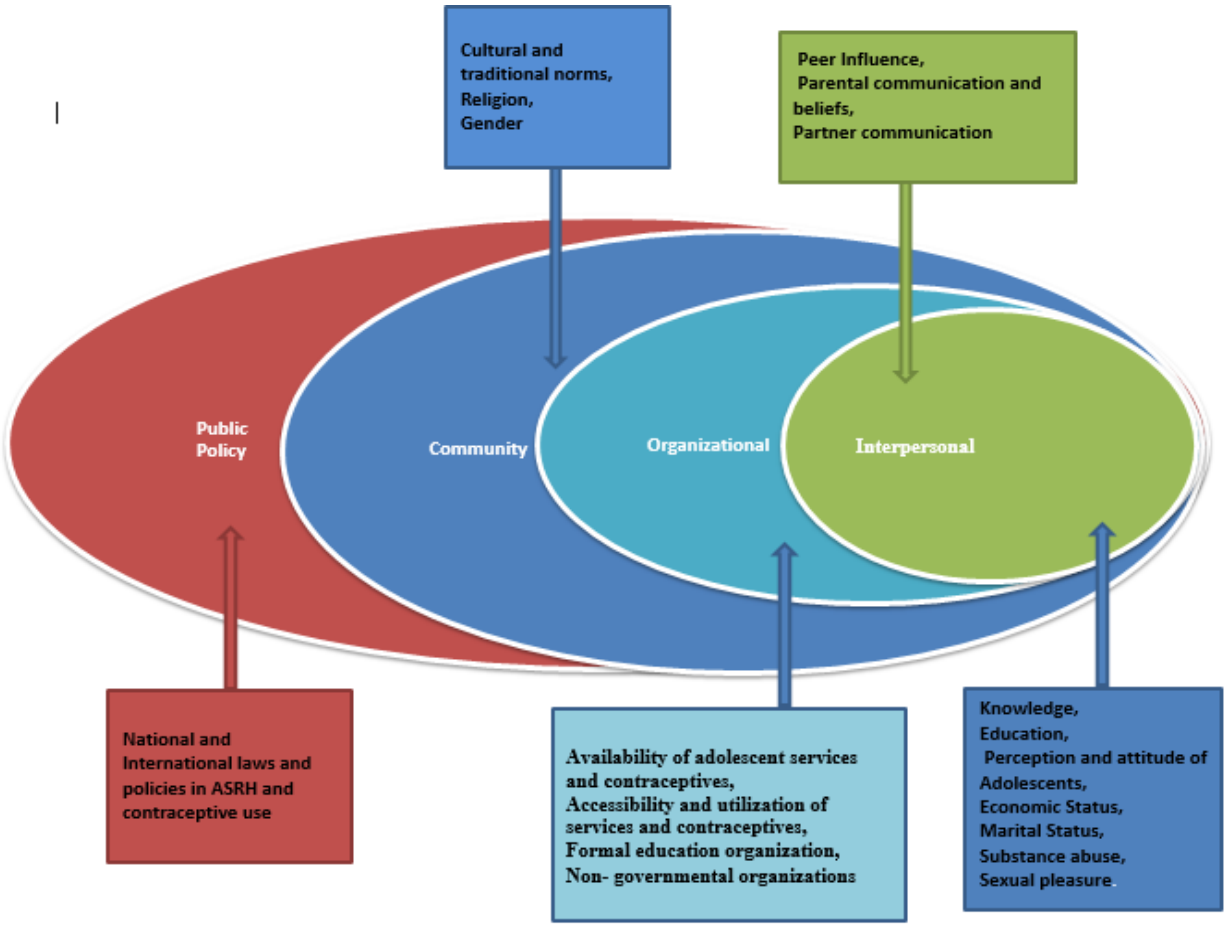

Figure 1 :Conceptual framework

Originally designed by McLeroy, 1988

1.4 Statement of the problem

One of the strategic objective of the National Condom Strategy of Malawi (2015-2020) is to increase the demand for and effective use of condoms through promotion of a youth-friendly condom distribution system (Ministry of Health, 2017). This strategy therefore intends to ensure that condoms reach all sexually active youths with an aim of preventing the spread of HIV and STIs or unwanted pregnancies. However, the distribution of condoms to adolescent learners in schools has provoked a debate among different stakeholders. So far, the Ministry of Education, Science and Technology, through its directorate stopped condom distribution in schools claiming that it contradicts the principle of abstinence promoted among adolescent learners (Gomani, 2017). Therefore, the conflict emerges when the Ministry of Health and organizations implementing condom distribution programs in schools claim that stopping sexually active adolescents from accessing condoms, expose them to a high risk of getting unintended pregnancies and contraction of HIV and AIDs and Sexually Transmitted Infections. On the other hand, some stakeholders, specially the Ministry of Education and religious leaders, claim that distributing condoms to adolescent learners has the potential of increasing sexual immorality among students. In the face of this controversy, this study examined stakeholders' values and attitudes towards condom distribution to adolescent learners in schools.

1.5 Aim and objectives of the study

1.5.1 Main objective of the Study

The aim of the study is to examine stakeholder's values and attitudes towards condom distribution to adolescent learners in secondary school in Nkhotakota, Malawi.

1.5.2 Specific objectives

i. To explore values and attitudes of stakeholders towards condom distribution to adolescent learners in secondary school in Nkhotakota.

ii. To assess the effect of stakeholders' values and attitudes towards HIV, STIs and pregnancy prevention.

iii. To identify differences in values and attitudes of adolescent learners towards condom distribution to secondary school learners in Nkhotakota.

1.6 Significance of the study

The significance of this study is based on the scientific consensus that condom use is an effective means of prevention of the transmission of HIV, STIs and unplanned pregnancies. Similar studies have been carried out on condom use among adolescent learners as a strategy for prevention of sexual transmission of HIV and AIDs. This study has applied ethical theories that may help to resolve conflicting stakeholders' values and attitudes towards condom distribution to adolescents in secondary school in order to reduce morbidity and mortality of adolescents. This study may be useful to the Ministry of Education, Science and Technology, the Ministry of Health, Medical Practitioners, Non-Governmental Organizations, researchers, faith groups, cultural groups and the Malawi citizenry in general as it offers an independent ethical clarification of condom distribution and use among adolescents.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of studies and policy strategies that have addressed the issue of adolescent sexual and reproductive health. It provides a review of the available literature relevant to this study in order to place this investigation within the context of similar studies. The chapter further presents a review and path to convergence approach of utilitarian theory, beneficence ethical principle and Public Health Six Part Analytical Ethics framework designed by Nancy Kass.

2.2 Risky sexual behaviour and school condom distribution programs

According to Boyer (2015), adolescents are at a risk of negative health consequences associated with unsafe sexual activity. Odimegwu and Somefun (2017) in their study on ethnicity, gender and risky sexual behaviour among Nigerian youth, described risky sexual behaviours at early age. These risks are experienced during the first sexual intercourse, when having unprotected sex, when having multiple sexual partners and when one lives with untreated sexually transmitted diseases. School condom availability programs have been promoted as a promising approach for increasing condom use among students, for reducing the risk of infections, and for preventing unintended pregnancy in order to promote sexual and reproductive health among adolescents (Brakma et al., 2017). The school condom distribution programs began across the United States. The greatest number of school districts implementing condom availability programs did so in 1991 and 1992. Most programs began before 1991 in USA, particularly in districts which have school health clinics (Douglas, 1996).

2.3 Policy guidelines and strategies on adolescent sexual and reproductive health

The 2011 Geneva World Health Organization guidelines recommends reducing marriage before the age of 18 years, reducing pregnancy before the age of 20 years, increasing use of contraception by adolescents at risk of unintended pregnancy, reducing coerced sex among adolescents, reducing unsafe abortion among adolescents (WHO, 2011). National Condom Strategy of Malawi (2015-2020) intends to increase the demand for condom use, raise awareness about HIV, STI and family planning, and make condoms accessible to adults ages 15 to 49 by 2020. Whereas, Youth Friendly Health Services Strategy (2015–2020) emphasises that the coverage and use of HIV prevention, care, and treatment services should be strengthened through programs that increase holistic awareness and knowledge among youths on sexual and reproductive health, abstinence, safe sex, sexuality, and HIV/STIs (Ministry of Health, 2014). Similarly, the Sexual and Reproductive Health and Rights Policy (2015–2020) highlights the strategic importance of the program and service integration for encouraging uptake of condom use (Pendleton, Mellish, Sapuwa, and Irani, 2015). The HIV Prevention Strategy (2015–2020) applies a combination of prevention framework that combines biomedical, behavioral, and structural interventions (National Aids Commission, 2014). Gender and HIV and AIDS Implementation Plan (2015) recognises condom programming as a key strategy in the HIV prevention agenda, especially as a means to addressing the gender inequalities and harmful gender norms that underscore risk and act as barriers to condom use.

Despite having these policies in place, most contemporary public health disease control and prevention efforts are a source of competing perspectives. Condom use among adolescents is earmarked to be effective in the prevention of HIV, STIs and unintended pregnancy prevention strategy although these efforts collide with other values (Romero Matson, and Sekelsky, 2016)**.** Several ethical questions arise on condom distribution, especially in Africa where religion and culture are strong and where they even seem to inform health decisions. According to Tuyisenge et al. (2018), the policy proposal to make condoms available in secondary schools aroused debates among different stakeholders in Rwanda in the late 2000s. This proposal was mainly supported by local and international NGO's in the health sector as a way of focusing efforts on promoting

adolescent sexual health in secondary schools. According to Kamanga (2018), school condom promotion policy supporters raised health related benefits, educational and empowerment reasons and social and economic reasons, whereas those disputing condom promotion perceived it to be against their cultural and religious sex norms. Given the environment where policy guidelines, proposals and recommendations focus on adolescent sexual health but inimical with the status quo, this study engaged various stakeholders' values and attitudes on adolescent sexuality.

2.4 Sources of knowledge of condom use and adolescent sexuality

Mucugu et al. (2013), in a study on condom use, awareness and perceptions among secondary students in Kenya established that there was limited information about the level of awareness among students about contraceptive use in the transmission of Sexually Transmitted Infections. It was further noted that adolescent students in secondary schools in Nakuru North District in Kenya were at risk of negative consequences of unsafe and unprotected sexual activities that expose them to STIs, HIV and unintended pregnancy due to lack of sexual health information (Mucugu, Migosi and Mwania 2013). For Cederbaum et al. (2014), sexual and reproductive health interventions among adolescents are linked to high numbers of youths living with HIV and AIDS and associated with increased risky sexual behaviours among Sub-Saharan African youth. However, adolescents in rural areas were found to be less likely to know where to obtain condoms than adolescents in urban areas because they are closely associated with higher education and greater access to services and media exposure (Mbarushmana, 2013). From what was observed, awareness of sexual health was key to the promotion of adolescent's sexual and reproductive health. To explore factors that can affect condom accessibility among adolescents, various sources of condom use and sexuality information were identified.

This thesis also assumed that knowledge about sexuality and contraceptives such as condom use is a critical element in achieving adolescent sexual and reproductive health. This knowledge is thus key to the formation of certain values, beliefs and attitudes towards condom use by adolescents in schools and particularly in secondary schools.

Whilst stakeholders' values, beliefs and attitudes are important in making ethical decisions in public health, various sources of knowledge about sexuality and condom use and distribution among adolescents were reviewed as outlined below.

2.4.1 Peer influence

Peer groups provide a place where adolescents feel accepted, where adolescents feel good about themselves, and where their self-esteem is enhanced. Having a group of friends to whom they can turn for advice and understanding enables them to operate in an environment of mutual trust (Widman, Choukas-Bradley, Helms, Golin, and Prinstein, 2014). According to Whitaker and Miller (2000), peers influence one another on condom use and norms related to sexual behaviour if parent-adolescent communication on sexual issues is limited. Widman et.al. (2014), observed that peer communication can have positive and negative influences on sexual norms among adolescents and it is a predictor of intention to engage in sexual debut. Sexuality information sharing of peer groups of adolescents anticipated a chance of decreased sexual risky behaviour (Widman et al., 2014). Boamah (2014), in their study which sought to determine knowledge of contraceptives in Kintapo, Ghana, discovered that most adolescents of about 88.9% reported to have knowledge on condoms.

Moreover, those who had discussed contraceptives before their first sexual intercourse were more likely to use condoms consistently than those who had not (Boamah, 2014). Unlike, the cultural and religious norms which restrain the unmarried adolescents from engaging in sex, the preceding literature surveyed reveals that peer communication plays a significant role in influencing adolescents to value condom use. This thesis also found out that peer influence is equally a significant source of information concerning sexuality and condom use among adolescents. Out of the 119 study participants, 60 (50.42) participants totally agreed, 39 (32.77%) participants agreed, 12 (10.8%) participants were neutral; 4 (3.36%) participants disagreed and 4 (3.36%) totally disagreed that they talked about sexuality and condom use with friends.

2.4.2 Parental influence

According to Kanda and Mash (2018), inconsistent condom use by young adults in Malapile, Botswana was caused by lack of sexuality and condom use communication between parents and their children. Another study in Hadiya zone, Ethiopia, determined minimal adolescent-parental communication on sexual and reproductive health. Most adolescents in secondary and preparatory schools reported that they could not openly talk about their sexual and reproductive health with parents even though they were aware of adolescent and youth friendly and reproductive health services (Kusheta, Bancha and Gesu, 2019). In all these studies data was collected using a qualitative method in which participants expressed themselves freely. However, this thesis used quantity method where responses were captured based on the level of agreement on five likert scale. Nevertheless, the results of this thesis confirm that there was limited communication between parents and adolescents on sexuality and condom use. This is evident from the results shown on the five likert scale which showed that 13 (10.92%) participants totally agreed, 18 (15.13%) participants agreed, 7 (5.88%) participants were neutral, 28 (23.53%) participants disagreed and 53 (44.54%) showed that they opened up with parents on sexuality and condom use issues.

Nevertheless, some studies have found a significant relationship between adolescent-parent communication with increased adolescent knowledge about their sexual and reproductive health. American Academy of Pediatrics (2013), reported that adolescent-parent communication increased sexual and reproductive health knowledge and condom use among adolescents. Girls who communicated with their mothers about STIs used condoms during their initial sexual intercourse than those who did not communicate with parents about sex and condom use. Thoma and Mhuebner (2018), in their study which used a theory of planned behaviour to examine YMSM perceptions of parent-adolescent communication on condom use, made a resolution that parent-adolescent communication about condoms influenced condom use among YMSMs who had openly communicated with their mothers on HIV related sexual risky behaviour. However, not many studies have been carried in Sub Saharan Africa including Malawi on how the relationship between parent and adolescents can influence condom use.

A randomised trial of schools of Cape Town and Mankmeng in South Africa and Dar es Salaam in Tanzania in which data was analysed comparatively, the results were consistent with an assertion that communication between adolescents and adults results into safe sexual practices among adolescents in schools (Muchiri, Odimegwu and De Wet , 2017). Specifically, communication between adolescents and adults likely affect the values and attitudes of adolescents towards condom distribution in Malawi.

2.4.3 Educational influence

Education also has an influence on the knowledge of condom use and sexual behaviour among adolescents. Adolescents who once attended sexual risk health lessons and those with functional literacy showed a high knowledge of sexual risk behaviours and a high response to condom use (Vongxay, 2019). American Academy of Pediatrics (2013) reported that comprehensive sex and HIV education and availability of condoms in schools increased condom use among adolescents. In this study most participants indicated that they discussed sexuality and condom use with their Life Skills teacher with varying levels of agreement or disagreement. Specifically, 61 (51.26%) participants totally agreed, 40 (33.61%) participants agreed, 5 (4.20%) participants were neutral, 5 (4.20%) participants disagreed and 8 (6.72%) participants totally disagreed.

2.4.4 Media exposure

Landry, Turner and Vyas (2017), in a study whose objective was to find a relationship between social media and the change in sexual risk behaviour, found a significant association between high a

ccess to media and increased sexual risk behaviour. It was postulated that social media increases a wide reach of partners and peer network which increases communication between those that are experienced and the unexperienced about sex which renders adolescents vulnerable to risky sexual behaviour as this affects their attitudes and social norms. This is consistent with the findings of the study on effects of mass media and internet on sexual behaviour of undergraduates in Osogho Metropolis, South Western Nigeria. Ready access to radio, television and the internet in Nigeria have increased access to explicit sexual materials to the youths that affect their sexual behaviour (Olarinmoye, Olarin, and Adebimpe, 2014). Explicit sexual material contained in social

media influences adolescents during early sexual debut which results in negative health outcomes such as transmission of HIV and STIs and early pregnancies.

On the contrary, a study in South Western Uganda on sexual health of very young adolescents revealed that 95% of the study participants knew sexually transmitted infections and contraceptive methods more from the radio than from their parents (Kemigisha et al., 2018). Media, therefore, plays a role as a predictor of knowledge about risky and safe sexual behaviour among adolescents. Through media, adolescents are informed of risky and sexual behaviour and in turn develop positive values and attitudes towards interventions meant to safeguard their sexual health.

2.4.5 Religious influence

Religion is another important predictor of condom use and sexual behaviour among adolescents. The protestants reported 5 times more likely to use condoms as compared to Catholics and Muslims in Tanzania (Njau, Mwakalo and Mushi, 2013). In another study carried among Portuguese university students, religiosity and spirituality did not affect condom use but did affect the sexual initiation stage among the youth (Gomes, 2015). Similarly, religious teachings expose adolescents to sexual subjects which focus on religious sexual attitudes which more likely aim at delaying sexual intercourse and having sexual partners as captured in African Journal of Primary Health Care and Family Medicine, Botswana (2018). Religious teachings, therefore, play a role on influencing knowledge of sexuality and sexual risky behaviour among adolescents. Therefore, this thesis intended to assess the influence of religious values especially Christianity and Islam on the knowledge of sexual and reproductive health and how this knowledge affect beliefs, values and attitudes towards condom use among adolescents in schools.

Religious values are a source of moral proscriptions for many individuals and they play a role in the formation of individual attitudes, values and decisions (Odimegwu, 2017). These attitudes, however, may translate to compliance with such moral prescriptions or may be a merely insincere proclamation of the same. This thesis intends to assess the

attitudes of adolescent learners towards condom distribution in schools in relation to their adherence to religious moral prescriptions.

2.4.6 Cultural influence

Ethnicity is an important social cultural factor mediating sexual behaviour in Sub Saharan Africa (Odimegwu and Sumefun, 2017). According to Odimegwu et al. (2018), individual and family knowledge levels regarding condom use and sexual behaviour in Africa differ by regional variation of social cultural practices. Ethnicity in a particular community can influence adolescents to engage in protective or risky sexual behaviour (Odmegulu, 2016). Ethnicity is described as a social group that shares a common distinctive culture, religion and language. De Jose (2013), in his study on sexual attitudes and behaviour of a cohort of adolescents aged between 15 and 24 found that the high percentage of male and female Pilipino youths valued virginity and opposed any other sexual behaviour. In the same respect, the study sought to establish whether cultural values directly influence sex behaviour and condom use among adolescents.

2.5 Values influencing policy, sexual behaviour and condom use

A wide range of values and attitudes have often resulted in blocking health and professional human sexuality services aimed at safeguarding adolescent sexual and reproductive health (PSI, 2016). Schalet et al. (2017) claim that science is the only essential foundation for adolescent sexual and reproductive health. Therefore, scientific methods are reliable and key to identifying a wide range of adolescent sexual and reproductive problems. In support of this thesis, the failure of American adolescent sexual and reproductive health policies is largely attributed to lack of scientific evidence to inform these policies (Brakma et al., 2017). It is further stated that moral beliefs that inform American sexual and reproductive health policies such as sex outside of heterosexual marriage is sinful and teaching about the health benefits of condoms and contraception is morally wrong because it encourages premarital sex (Brakma et al., 2017).

Although scientific evidence can be relevant in the formulation of adolescent sexual and reproductive health policies, this thesis examined stakeholders' values and attitudes towards condom distribution in schools from an ethical point of view. Therefore, both empirical and philosophical methodologies were employed in examining different stakeholders' perspectives.

2.6 Beliefs, attitudes and condom access

Adoun et al. (2015) found that condoms are beneficial in the prevention of sexually transmitted infections and unintended pregnancies and most respondents to the study found no disadvantages for adolescents to be given condoms. Respondents highlighted that having access to condoms, and having proper information about condoms are the most important factors facilitating condom use (Adoun, 2015). Other studies in America also demonstrate that condom availability in schools is associated with increased condom use and overall sexual health among adolescents. For that reason, the Society of Adolescent Health and Medicine encourages health providers to advocate for the availability of condoms in schools in order to reduce rates of STIs and unplanned pregnancies (Brakma et al., 2017).

Wanje and Masese (2017) found that many parents in Kenya would rather talk about the consequences of sexual health and not preventive methods. These parents could not suggest that their children should use sexual protective measures because they felt it was immoral for adolescents to use contraceptives and condoms (Wanje and Masese, 2017). Therefore, condom use could not be recommended to adolescents since sexual activities were strictly reserved for married people. The main objective of this study was to identify parents' and teachers' attitudes towards different preventive methods in sexual and reproductive health. Nonetheless, this study sought to identify beliefs and attitudes of adolescent learners in schools towards condom distribution.

Similarly, a review of literature and policy documents on reproductive and sexual health in Rwanda revealed that there were attitudes of religious leaders which were strongly opposed to condom distribution and use by adolescents in schools (Abbott & Muttesi,

2014, 25). Smith and Harrison (2013) investigated the attitudes of 43 teachers and school administrators towards sex education, young people's sexuality and their communities in 19 secondary schools in rural KwaZulu-Natal, South Africa, and how these attitudes affect school-based HIV prevention and sex education. During interviews, teachers opposed condom distribution and use among adolescents in schools as they perceived it to be immoral, and they could not consider it as a strategy to minimize HIV risk (Smith and Harrison, 2013).

Based on the literature reviewed, it has been shown that different stakeholders have differing values and attitudes towards adolescent sexuality. However, the literature did not present the learners' attitudes towards condom use, and it is this gap that this study intends to fill. If prevention of sexually transmitted infections and pregnancies depends upon both accessibility of condoms and proper information, then the moral values and attitudes that stakeholders have toward condom distribution to learners must be ethically weighed and examined. Therefore, the following question arises: "what are the competing stakeholders' values and attitudes concerning condom distribution to adolescent learners in secondary schools in Malawi?"

2.7 Theoretical framework: Review and path to convergence approach

The conceptual framework provides an ideal situation on the ground which provides a road map necessary to inform the study. To make the discussion of the collected data meaningful, this section discusses a theoretical framework that informs this study. Osanloo and Grant (2016) assert that "theoretical framework" is a term used to mean a general guide to decision making or the practice that identifies key concepts or ideas that need to be taken into account and that can sometimes explicate the relationships among the concepts. Currently, public health ethics frameworks appear to offer no common unifying philosophical theory, common foundational values, and provides a few consistent operating principles to resolve public health dilemmas (Buse, 2008). For this reason, a review of several frameworks was employed as a path to convergence to help in reconciling policy dilemma and different stakeholders' views with an aim to achieve desirable health outcomes for the adolescents in secondary schools. Therefore, a review

of utilitarian ethical theory, beneficence ethical principle and Kass's ethics framework for public health practice were used to examine values and attitudes against or in support of condom distribution to adolescent learners in secondary schools. The three frameworks were used to minimise weaknesses of each framework and also to consider different stakeholder views.

2.7.1 Utilitarianism

This study used the utilitarian ethical theory developed by Jeremy Bentham (748-1832) and embraced by John Stuart Mill (1806-1873). Utilitarianism, as a theory, is based on the principle that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness (Mill,1998). According to Riley (2001) Mill held that human actions should primarily intend to maximise happiness and reduce unhappiness of the greatest number. Utilitarianism is one of the ethical theories that are used to examine stakeholders' values and attitudes towards condom distribution to adolescent learners.

Utilitarian theory falls within normative ethics. Normative ethics is the systematic investigation of moral standards (norms and values) with the purpose of clarifying how they are to be understood, justified, interpreted and applied on moral issues (Galmund, 2012). Utilitarianism therefore rejects the absolute application of moral codes or systems that consist of commands or taboos that are based on customs, traditions or orders given by leaders or supernatural beings (Kagan, 2018). It thus evaluates the practicability of any moral prescriptions based on the outcome hence considered to be one of the consequentialist theories.

Public health ethics is one of the emerging subfields of bioethics and has lately been discussed vigorously. Among the central questions of public health ethics is the balance between individual freedom and the common good realised through public health interventions (Pinto and Upshur, 2009). Maximizing theories such as utilitarianism are the core of public health ethics deliberations. These theories or principles elucidate that justice requires that health care should be distributed in order to bring about the best

possible consequences (Ogunkoya, 2011). In the context of public health, any intervention should aim at maximising health of the aggregate population. It should however be noted that the utilitarian theory employed in this thesis seeks to explicate the pattern of examining data on values and attitudes of the study participants focusing on achieving aggregate health goals.

2.7.2 Non-deductive principle based approach

This study employed also beneficence ethical principle developed by Beauchamp as a tool to guide ethical decisions in the field of health. The reason behind the use of this ethical principle is to examine each stakeholder's values and attitudes towards condom distribution to adolescents in secondary schools. This ethical principle was coined by Beauchamp under the influence of common morality developed by Bernard Gert (Olaru, 2010). The principle of beneficence is one of the four biomedical principles which is based on common morality (Daly, 2014). According to Daly (2014), Beauchamp and Childress account for four ethical principles; beneficence, none-maleficence, respect for autonomy and justice as principles which provide a general guide for justification of moral judgments and ethical decisions. The principle of beneficence entails a moral obligation to help other persons (for example, obligations of health professionals to assist patients) or to provide benefits to others, and it involves both the protection of individual welfare and the promotion of the common welfare (Beauchamp, 2009). However, this principle alone does not reconcile the different stakeholder perspectives to elucidate moral grounds for their actions. It is from this background that this study incorporates reasons for acting from Bernard Gert's common morality to augment the principle of beneficence.

According to Daly (2014) common morality is the set of norms shared by all persons committed to morality by which they rightly judge the conduct of all persons in all places. That is, ethical decision making should start from these common experiences and should identify the principles or values liable to be recognised as widely as possible, and should not proceed from an abstract level down to concrete cases (Olaru, 2010). This concept therefore goes beyond restricting morality to particular beliefs, customs and

attitudes, but it is analogous of universal principles of morality on how humans of all societies base their reasons for acting.

Therefore, this section provides a summary of Bernard Gert's reasons for acting (Gert, 2004). A reason for acting is a belief that one's action will avoid harm or gain benefit for anyone and not merely oneself. The reason that one's action will avoid harm or gain benefit for anyone, makes the account of rationality neutral rather than siding with self-interest over morality. Morality is largely concerned with the harm and seeks to find solution to this by promoting benefits of oneself or other people. It is irrational not to avoid harm for oneself unless one has adequate reasons not to avoid them, or it is irrational to avoid benefits for oneself unless one has adequate reasons to avoid them. Harms are classified as death, pain, disability, loss of freedom and loss of pleasure while the benefits (goods) are consciousness, lack of pain, ability, freedom, and pleasure.

2.7.3 Public health practice based framework

In the light of condom distribution among students in secondary schools as a public health intervention, an ethics framework devised by Nancy Kass in 2001 was employed to evaluate ethical implications of secondary school condom distribution programs. Kass's ethics framework for public health is not a code of professional ethics that address general norms and expectations of professional behaviour, but it is a six-part analytic framework designed as a tool to help public health professionals as they consider the ethics implications of proposed programs, interventions, research initiatives, and policy proposals (Kass, 2001, p. 1780). The six parts are as follows:

i. What are the public health goals of the proposed intervention, policy, or program? This calls for identifying the ultimate health goal that is the reduction of morbidity and mortality.
ii. How effective is the intervention or program in achieving its stated goal? This question seeks to identify intermediate steps towards meeting the stated goals.
iii. What are the known or potential burdens of the program? This step intends to explore the program's risks to privacy or confidentiality, autonomy and liberty, justice and the health of individuals.

iv. How can the burdens be minimised? This helps to assess the alternative approaches if they can achieve the same goals. Ethically, the approach that poses fewer risks than other moral claims, such as liberty, privacy, opportunity, and justice, assuming benefits are not significantly reduced, is chosen.

v. Is the program implemented fairly? This question intends to ascertain if the benefits and burdens of the program are distributed equitably.

vi. How can the public health benefits be balanced? This calls for fair procedures when considering differing views. The planning takes a democratic process or a form of procedural justice to determine if the balance between benefits and burdens is equitable.

2.8 Summary

This chapter has reviewed literature from various sources. It has also presented the utilitarian ethical theory, ethical principle and the practice based on six-part analytic ethics implication framework. These ethical theories are applied on the study results during examination of the values and attitudes towards condom distribution. All the theories were employed to minimise the weaknesses of each framework since ethical issues are diverse.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methods employed in this study in order to meet the intended objectives. It presents the study's research design, data collection methods and data analysis techniques. It describes also the manner in which research participants were identified to source relevant data.

3.2 Study design

The study used the cross sectional research design, particularly the mixed method of combining qualitative and quantitative methods. Mixed method approach was used to draw on the strengths and minimize the weaknesses of both types of research methods. As pointed out by Creswell(2014), the qualitative method provides a comprehensive analysis of the research questions posed while the quantitative method minimises subjectivity of results by providing tangible statistical results.

Quantitative research often improves on the validity of research instruments as well as the provision of a numerical dimension to analysis when addressing a phenomenon. Quantitative research also simplifies human experience, and statistically making the analysis of the research findings easier. Qualitative studies, on the other hand, take into account the lived experiences hence enabling contextualization of the analysis of the phenomena, and also allows for in-depth understanding of the phenomena since they are often structured to collect data over an extended period of time.

The logic of inquiry in a mixed research encompasses the use of induction (i.e. delivery of patterns), deduction (i.e. testing of hypotheses and theories), and abduction (i.e. uncovering and relying on the best set of explanations for understanding one's results

(Creswell, 2014). Therefore, the mixed methods approach was chosen in order to present a logical and intuitive appeal, hence providing a platform for bridging the gap between quantitative and qualitative paradigms.

3.2 Study setting

The study was conducted in Nkhotakota District. It was particularly conducted at two secondary Schools. One school was located at the Centre of Nkhotakota urban and the other one was situated in rural area about 10 kilometers away from Nkhotakota urban, along the lake shore of Lake Malawi, Central Region of Malawi.

3.3 Study population

The study population involved adolescents aged between 15 and 19 registered in secondary school, policy makers, school administrators heading both day and boarding schools, youth friendly service providers; implementers of the condom strategy both in government hospitals and non-governmental organizations and religious leaders.

3.4 Sample size

3.4.1 Sample size calculation

The sample that was included in the study was drawn from a population which was assumed to be infinite. At 5% significance level the sample size was calculated using the following formula:

$$n = \frac{p(1-p)z_{\alpha/2}^2}{d^2}$$

Where:

- The sample proportion (ρ) is approximately equal to the population (p), ρ-p <d and $d = 0.10$, $\alpha = 0.05, 1 - \alpha = 0.95$ (i.e. the probability that $\rho - p < d$) then $Z\alpha_{/2}$ (i.e. $Z_{0.05}$) from the normal distribution tables is 1.96.
- p/(1-p) is the proportional variance whereby when it is maximum it is equal to 1/4.

Thus sample size (n) was: $n = \frac{1.96^2}{4 \times 0.01^2} = 96.04$.

This implies that the minimum sample size which was required to be included in the study was 97 adolescent learners of both sexes aged between 15 and 19. The study intended to involve 120 adolescent learners, 60 from each sampled schools. However, only 119 turned up to give responses.

3.5 Selection of study informants

The study used purposive sampling and simple random sampling in order to obtain the respondents. Study participants for qualitative data was purposively sampled and these included policy makers, service providers, school heads and religious leaders.

Creswell (2014) defines simple random sampling as the basic sampling technique where we select a group of subjects (a sample) for study from a larger group (a population). Each individual is chosen entirely by chance and each member of the population has an equal chance of being included in the sample. Therefore, participants who were interviewed were selected using simple random sampling technique. Participants were selected from each class, that is from form one to form four. This implies that every student of either gender aged between 15 and 19 had an equal chance of being included in 15 participants per class. Similarly, any student from the sampled schools had an equal chance of being included in the sample of 120 participants of the study. The researcher also triangulated the quantitative results with two focus group discussions comprising 12 participants. The discussion focused on the adolescents' values and attitudes towards condom distribution in secondary school.

3.6 Data collection process

The structured questionnaires were administered to participants for the quantitative study. The data collection process through the use of a questionnaire was interviewer driven. This implies that questions were read to the participants to maximise clarity in case there would be questions. Data that was collected included knowledge, values, attitudes/beliefs of individual adolescent learner towards condom distribution in secondary schools.

Participants were given a five point likert scale statements to ascertain the degree of their agreement or disagreement about the statements (See appendix 1).
The in-depth interview guide was developed in English and Chichewa for policy makers, head-teachers and service providers and religious leaders to give them freedom to use the language which they could feel comfortable communicating with. Responses during interviews were recorded using a tape recorder and also using written transcripts. Informed consent and assent were sought before data collection.

Eight key informants took part in-depth interviews. On policy direction, one interview was conducted at Nkhotakota District Health Office to obtain information on what the policy says regarding condom distribution in schools. Another interview was conducted at Nkhotakota District Education Office to find out what the National Education Policy says on adolescent sexual and reproductive health in relation to condom distribution strategy.

Two headmasters were interviewed. One was from a Secondary School situated in urban area comprising of both residential and non-residential students, a kilometer away from Nkhotakota urban main market. The other headmaster was from the Secondary School situated in the rural area of Nkhotakota about 10 kilometers away from Nkhotakota urban main market.

Youth friendly service providers were also interviewed to find out if secondary school adolescents access condoms at their service centers and explore other factors that affect condom accessibility.

Two religious leaders were interviewed on their values and attitudes towards condom distribution to learners in secondary school. These religious leaders were purposively selected and included a sheikh and a pastor since Nkhotakota is influenced by two major religions Islam and Christianity.

3.7 Data management and analysis

3.7.1 Quantitative data

The data collected through questionnaires was kept in a locked drawer where only the researcher had access to the information. The data collected was later entered into stata version 12.0 for analysis. To ensure accuracy of the data, the researcher independently cross-checked the data twice. Univariate and inferential analysis were taken into consideration.

3.7.1. 1 Univariate analysis

Univariate analysis focused at the descriptive statistics of the different variables by looking at their percentages, frequencies, mean, standard deviations and ranges.

3.7.1.2 Inferential Analysis

Inferential analysis used Kruskal Wallis analysis and Mann Whitney analysis on various variables with respect to other variables. The hypothesis for both analyses was;

H_0: There is no difference in levels of agreement in different likert scale with respect to other variable.

H_1 : There is a difference in levels of agreements in different likert scale with respect to other variable.

The Kruskal Wallis formula was;

$$H = \frac{12}{n(n+1)} \sum \frac{T_i^{\,2}}{n_i} - 3(n+1)$$

Where

- Rank the total measurements in all k samples from 1 to n.
- T_i= rank sum for the *i*th sample I = 1, 2,…,k.

We reject H_0 when p-value is less than 0.05 at a specified level $\propto$. Otherwise, the null hypothesis is adopted and a conclusion is reached accordingly. Kruskal Wallis was performed where the other variable has more than two categories such as age.

Mann Whitney formula was;

$$U = (n_1)(n_2) + \frac{n_2(n_2+1)}{2} - \sum_{i=n_1+1}^{n_2} R_i$$

Where

- n_1 is the size of sample one.
- n_2 is the size of sample two.
- R_i = Rank of sample size.

We reject H0 when p-value is less than 0.05 at a specified level $\propto$. Otherwise, the null hypothesis is adopted and a conclusion is reached accordingly. Mann Whitney was performed where the other variable has only two categories such as gender, residence and religion.

3.7.2 Qualitative data

Interviews were audio recorded and transcribed into a Microsoft Office word sheet. Transcribed data was manually sorted and grouped based on the themes such as history of condom distribution policy, policy and moral dissonance, school condom distribution programs awareness, stakeholders' perceptions, school condom distribution challenges and results of negative sexual behaviour. Content analysis was used to that effect.

3.8 Ethical considerations

First, the questionnaire was accompanied by an introductory letter from Chancellor College Philosophy Department. The letter described the purpose of the study. The researcher also explained to participants on how the data would be collected from the participants and that there would be confidential treatment of data.

Secondly, informed consent from all adult participants and key informants was obtained before data collection while assent was sought from the parents of the minor participants through their headmasters who acted also as their surrogates. The researcher also obtained permission to conduct the study from College Private Secondary School, Kasamba Community Day Secondary School, Foundation for Community Capacity Development (FOCCAD) and Nkhotakota District Hospital (DHO). In addition, the proposal was sent to the Department of Philosophy for ethical approval. Consent or assent form was in English and Chichewa since the researcher assumed that some participants may not understand English. No personal identifying information appeared on the research records and the interviews took place in a private place away from the

traffic of other people or participants. Data obtained from the study interviews were kept in a secure place, a cupboard, of which the keys were kept by the researcher. This ensured that the confidential information generated from the study was well secured.

3.9 Study limitations

The main constraint of the study is lack of recent and relevant literature on condom distribution among adolescent learners in secondary schools. However, the researcher identified literature which dealt with condom use and the adolescents in general. The short time of the study was another limitation as this resulted in reduced sample size hence affecting statistical power. In addition, the questionnaire which was used to collect data from the study participants was not semi-structured which limited them from expressing themselves comprehensively.

CHAPTER 4
STUDY RESULTS

4.1 Introduction

This chapter presents data on values and attitudes towards condom distribution among adolescent learners in secondary schools in Nkhotakota, Malawi. The first part of this section presents qualitative data collected from eight key informants of the study using qualitative method. The other part presents the quantitative and qualitative data from the study participants.

4.2 Values guiding policies or programs on condom distribution and sexuality

First, key informants were asked to explain the values guiding the policies of their ministries. The questions that were used to capture the values guiding condom distribution policies or programs and adolescent sexuality were: "What was the aim behind initiating and implementing the condom distribution policy or program and how does distributing condoms to adolescents in secondary school conflict with your adolescent sexual and reproductive health policy? Describe values attached to these policies or programs?"

4.2.1 Ministerial policy values

The Ministry of Health's Essential Health Package policy which includes maternal health and family planning recognises the 2004 condom strategy and its succeeding 2015-2020 condom strategy (Ministry of Health, 2017). Therefore, Essential Health Package policy through Malawi Condom Strategy (MCS) gives mandate to medical and all public health practitioners to distribute condoms to those who need them and all risk groups including students in schools.

> *Where life is under threat we try our best to save it. In the context of distributing condoms in schools, we want to deal with threats to life that*

come because of HIV, STIs and unsafe abortions among students. Moreover, we feel the age groups in secondary schools need our intervention since they are in their sexually active stage (KF1, personal communication, March 4, 2019)**.**

The key informant from the education sector particularly on policy direction regarding condom use among adolescents in secondary school observed that the 2013 National Educational Policy does not allow students to have sex in schools.

We promote abstinence since adolescents and all students in secondary school are not expected to have sex since sexual activities are strictly for adults. He further said that there was nowhere in the policy where the distribution of condoms to students is allowed as this can contradict the Education policy (KF2, personal communication, May 17, 2019).

4.2.2 Program values

The values of the condom strategy aim at preventing harm, and do not aim at encouraging sexual immorality.

We equally try to discourage sex among adolescents in our programs but we have to be realistic that those efforts may not yield any good results because the youths will continue engaging in sexual acts. Coming up with condom strategy, we are not here to encourage sexual immorality but to prevent the harm that can be caused if adolescents continued to have unsafe sex (KF3, personal communication, February 24, 2019).

4.3 Religious values regarding condom use and sexuality

4.3.1 Christian and Islamic teachings against condom use by adolescence

Both Christian and Islamic teachings discourage the use of condoms based on biblical and qur'anic teachings. As one respondent observed:

Islamic faith regards condom use as immoral and sin before Allah since adolescents are not allowed to use condoms as sex before marriage is

forbidden in the Quran and the youths are expected to abstain from sex (KF7, personal communication, March 1, 2019).

Another respondent further said:

We always encourage young ones to abstain from sexual practices. Adolescents should not engage in sex. We know other adolescents do have sex but that is unacceptable and sin before God. I can give you a Bible verse, Deuteronomy 22:13 says girls should not sell their virginity. This is our basis and we encourage our girls to do so. Another important verse is Job 31:31 which restrains boys from being lustful to maintain sexual chastity. (KF8, personal communication, May 20, 2019).

4.2.4 Stakeholders' attitudes towards condom distribution in schools

The following question was used to capture data for stakeholder's attitude towards condom distribution among adolescents in secondary schools, ***"****What are your views towards condom distribution to adolescents in secondary school?"* Furthermore, during interviews it was observed that stakeholders had different attitudes towards condom distribution in secondary school. They expressed statements such as;

I can give you an example why we have problems with this at policy level. This will increase sexual practices among students. When I served as Deputy Headmaster, one NGO came to distribute condoms to almost all students who were there. The next day, we found used condoms all over the campus and what is that? The year in which condoms were distributed many girls withdrew due to pregnancies (KF2, personal communication, May 17, 2019).

Young minds have a curious mind if they tried sex with a condom and later they would need to try it without the condom. If adolescents tried both, the preference would definitively be having sex without a condom and this could put them at risk of contracting HIV, STIs and getting pregnant (KF2, personal communication, May 17, 2019*).*

I strongly feel this will surely promote sexual immorality because students will be exposed to sexual practices a problem we will not be able to solve. We fear if they do not have condoms they will simply do it without a condom which puts them at a greater risk of getting infected with HIV. We are against sexual intercourse among adolescents. The children we are raising today are very clever that when they have easy access to those condoms, they will think of experimenting. "No sex! It is sin before Allah (KF7, personal communication, March 1, 2019).

Even if condoms were made available in schools for easy access there would be problems since some adolescents still get pregnant, STIS and HIV given the availability of free condoms in hospitals and NGOs. Condoms have a chance of breaking and should not be guaranteed as a solution.

*We receive cases of girls with complications caused by unsafe abortions on daily basis. Most of these patients are school going age and their records show that they are registered students in either primary or secondary schools around. This will promote our coverage to beneficiaries of sexual and reproductive health services. Adolescents in secondary schools will be protected from HIV, STIs and death due to unsafe abortions (*KF3 Personal Communication, 2019).

4.2.5 Effects of values and attitudes towards condom distribution

The study also sought to understand the sexual behaviour of adolescents as to whether schools should promote abstinence or allow condoms to be distributed among adolescents in schools. The study generated a variety of cases for consideration.

Case 1:

What is disheartening is the fact that many girls will access our services when they have complications of unsafe abortion related problems. Of recent, we have had a case of a female student from one of the schools around this

area who conducted an abortion through traditional means and developed complications. She came to seek our service when it was too difficult for us to save her and she died while we were trying to help her (KF4, personal communication, February 28, 2019).

Case 2*:*

Another related case is that of a 14 year primary school girl whom we had been assisting through our ART clinic. She was tested HIV positive right at this hospital and was introduced to our counseling services where she was encouraged to start taking ARVs. She had been coming on a regular basis but she later disappeared. Just last week she came with her parents in a deteriorated health state. She had defaulted drugs and we later realised that she was pregnant. She disclosed to us that it was her fellow primary school pupil who was responsible for the pregnancy. You can see that it is most likely that this girl transmitted HIV to the boy who made her pregnant. This is really a challenge because primary and secondary schools can equally be our convenient areas to distribute condoms to help in reducing transmissions of infections (KF4, personal communication, February 28, 2019).

Case 3:

S*everal youths open up at our teen clubs, on their engaging in sexual activities. We had a case of a 17 year old boy who was at the time schooling at a nearby community day secondary school. He tested positive and began taking ARVs without the knowledge of his parents. He fell very sick because he had defaulted drugs. When he was taken to hospital, his parents were angry at him to learn that he acquired the virus at that young age. He was recommitted on ART and he is now fine and he is doing his studies in one of the public universities. As I said that he acquired HIV while he was in secondary school, a shocking witness he made to us was that he could sleep with seven girls without using a condom within a week and most of them were his school mates. You can see, there was high chance of infecting*

others and likely he was not the only person doing that (KF3, personal communication, February 2, 2019).

Case 4:

We had a serious case as a school where a girl induced abortion in our hostels leading to her arrest. We have cunning students with clever schemes who trick us administrators pretending to go outside on the pretext that they are sick while they are going out to have sex. Cases such as these, show that abstinence is not the only way out, we need to increase efforts but I don't know how because distributing condoms directly can come with challenges. (KF5, personal communication, February 3, 2019).

4.3 Univariate analysis

This sub-section presents data collected using a five likert scale question to identify differences in knowledge, values, and attitudes towards condom distribution among secondary school learners in Malawi. Univariate analysis focused on finding out from respondents against the different variables by looking at their frequencies, percentages, range, mean, mode and standard deviations.

4.3.1 Social demographic characteristics of study participants

Data was also obtained from secondary school learners from two schools, one from an urban and the other form rural settings. As shown in Table 1 below, a total of 119 learners took part in the self-administered survey. Sixty-one learners were recruited from an urban setting while fifty-eight learners were from a rural setting. Out of the total number of participants recruited, 59 were male and 60 were female. Participants were randomly selected from forms one to four. The distribution of the recruited students per form was as follows: 25 from form 1, 30 from form 2, 30 from form 3 and 34 from form 4. The mean age of study participants was 16 (±3). The age range was 15 to 19 with the standard deviation of 1.412702. 77 participants were members of the Christian faith while 42 were Muslims.

Table 1: Social Demographic Characteristics of Study Participants

		Male (59)	Female (60)	Total
Class of the respondent	Form 1	12	13	25
	Form 2	15	15	30
	Form 3	15	15	30
	Form 4	17	17	34
Age of the respondent	15 years	8	9	17
	16 years	10	14	24
	17 years	9	4	13
	18 years	12	23	35
	19 years	20	10	30
Residence of the respondent	Urban	30	31	61
	Rural	29	29	58
Religion of the respondent	Christianity	34	43	77
	Islam	25	17	42

4.3.2 Sources of information on condom use and sexuality (N = 119)

Table 2 shows different ways on how adolescents in Nkhotakota are informed about condom use and their sexuality. This section presents results collected using a five likert scale where participants responded by indicating their level of agreement, and the percentages that follow shows total agreement. 68 (57.14 %) of the study participants indicated that they access information about condom use and sexuality from the hospital, 61 (51.26%) from life skills teacher, 60 (50.42%) from peer communication, 50 (42.02%) from sex partner communication, 44 (36.97%) from non-governmental organizations' awareness programs, 42 (35.9%) from radio and television communication, 38 (31.93%) from youth club communication, 26 (21.85%) from song information, 24 (20.17%) from counselor communication, 13 (10.92%) from parents communication, and 9 (7.56%) from signpost information.

Table 2: Sources of Information on Condom Use and Sexuality (N = 119)

	Life skills teacher	Parents communication	Peer communication	Radio communication	Sex partner communication	Youth club communication	Signpost information	Song information	Village counselors communication	Hospital information	NGO programs
Totally agree	61 (51.26%)	13 (10.92 %)	60 (50.42%)	42 (35.29%)	50 (42.02%)	38 (31.93%)	9 (7.56%)	26 (21.85%)	24 (20.17%)	68 (57.14%)	44 (36.97 %)
Agree	40 (33.61%)	18 (15.13 %)	39 (32.77%)	41 (34.45%)	29 (24.45%)	28 (23.53%)	22 (18.49%)	45 (37.82%)	21 (17.65%)	36 (30.25%)	43 (36.13 %)
Neutral	5 (4.20 %)	7 (5.88%)	12 (10.08%)	10 (8.40%)	16 (11.76%)	17 (14.29%)	15 (12.61%)	19 (15.97%)	21 (17.65%)	15 (5.88%)	15 (12.61 %)
Disagree	5 (4.20 %)	28 (23.53 %)	4 (3.36%)	15 (12.61%)	16 (13.45%)	16 (13.45%)	29 (24.37%)	13 (10.92%)	21 (17.65%)	3 (2.52%)	6 (5.04 %)
Totally disagree	6.72 (	53 (44.54 %)	4 (3.36%)	11 (9.24%)	10 (8.40%)	20 (16.81%)	44 (36.97%)	16 (13.45%)	32 (26.89%)	5 (4.20%)	11 (9.24 %)

4.3.3 Values influencing sexual behaviour and condom use

Further, participants were asked to indicate the level of agreement or disagreement on the values they respect that can either influence them delay or initiate sexual practices and at the same time help them to see the importance of condom use. This section presents results of response rate based on percentage of agreement or disagreement from the highest to lowest as indicated on the likert scale. Findings from responses are presented in pie charts.

4.3.3.1 Respecting religious values and not engaging in sexual practices

On the question whether adolescents respect religious values for them not to engage in sexual practices, 16 (12.45%) agreed and 35 (29.41%) totally agreed that they respected their religious values that promote abstinence. During interviews it was observed that some participants could show adherence to religious sexual norms. This was shown by statements like*;*

> *I am a Muslim and our religion does not allow sexual intercourse among adolescents. We value virginity. As students we must abstain from sex and we should not use condoms because doing so is uncleanliness and sin before Allah. We should wait until we get married* (Study participant, 2019).

Other 31 participants representing (26.05%) of the sampled population totally disagreed that religious values restrained them from sexual practices. Relatively, another group of adolescents representing 23 (19.33%) of these study participants disagreed that religious values do not make them abstain from sex. Furthermore, it should be noted also that during interviews some participants could express statements that they do not adhere to religious sexual norms. Some of the statements include;

> *In our church we are not allowed to have sex before marriage and that is a rule. If this rule was followed by adolescents, we would not be having cases of pregnancies in the church. This clearly shows that sex take place among us church going adolescents. Since it is the expectation of the church that girls should not get pregnant out of wedlock, I value condom use to prevent*

disgracing parents and myself if I get pregnant since I do not adhere to the church values (Study participant 2019).

My religion forbids sex before marriage especially among us adolescents. I personally do not value such rules but I value my feelings. When I feel like having sex, I do everything to satisfy myself. Condoms are good to me because I only enjoy sex without having to worry about other bad consequences especially us girls like getting pregnant (Study participant, 2019)

However, 16 (14.45%) study participants indicated that they were neutral on whether religious values influence them to abstain from sexual activities or not. The mean of study participants was 23.8 with standard deviation of 1.59 in the range of 14 to 35 participants.

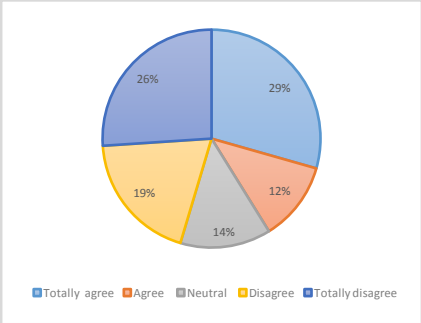

Figure 2: Respecting Religious Values and Not Engaging In Sex

4.3.3.2 Respecting cultural values and not engaging in the sexual practices

Another question intended to find out if adolescents respect cultural values to abstain from sexual practices. Out of 119, 19 (15.97%) agreed, 11 (9.24%) totally agreed and 17 (14.29%) were neutral that they respected cultural values not to engage in sex. On the other hand, 38 (31.93%) study participants disagreed and 34 (28.57%) totally disagreed that they respect cultural values not to engage in sexual practices. When asked in an interview if they valued cultural norms that restrain sexual practices, respondents stated that "*we are no longer following cultural traditions these days. Culture has changed due to media influence. We watch pornographic films and explicit sexual images which make us develop interest in sex so we need to use condoms for protection."*

The mean of study participants was 23.8 with standard deviation of 1.31 in the range of 11 to 38 participants.

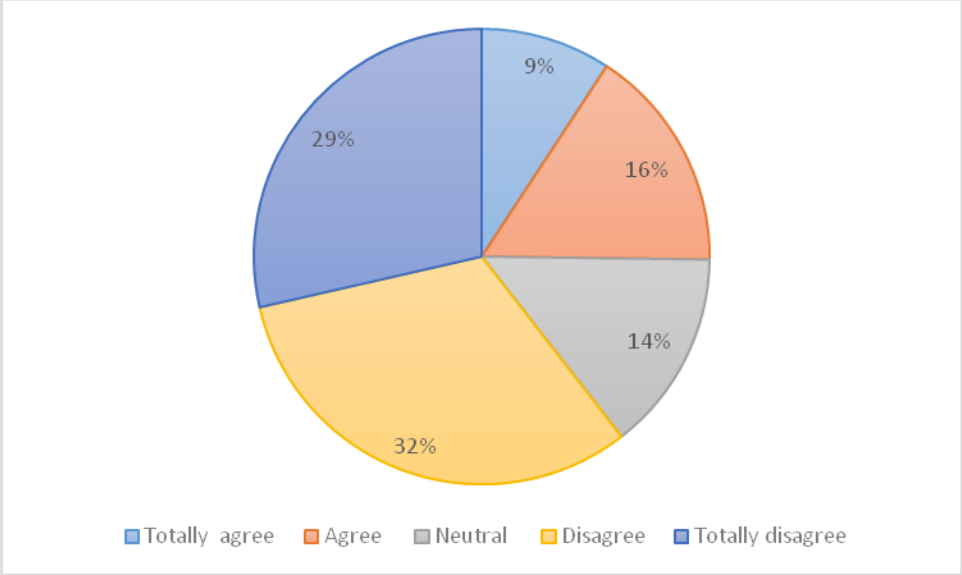

Figure 3: Respecting Cultural Values and Not Engaging in the Sexual Practices

4.3.3.3 Respecting family values and not engaging in sexual practices

Study participants were also asked to respond to the question that sought to establish if adolescents adhere to family values that promote abstinence. 20 (16.81%) disagreed and 39 (32.77%) participants totally disagreed that they respected family values that encouraged them to abstain from sex. During interviews some participants expressed statements such as;

> *I know parents cannot be happy with us being given condoms but what matters are our life and education. There is nothing we can do but use condoms since I engage in sexual actives regardless of parents' advice restraining me from engaging in sex* (Study participant, 2019*).*

> *We do not openly talk about sex in our family. Family sexual norms are not clear to us, we now value condom use because of what we learn in school and from the programs promoting condoms. Parents do not even know that we use them since we do not practice sex in public so sex is a personal thing* (Study participant, 2019).

Whereas 25 (21.01%) participants totally agreed, 19 (15.97 %) agreed while 16 (13.45%) of these study participants were neutral on whether they respected family values in favour of abstinence. The mean of study participants was 23.8 with standard deviation of 1.48 in the range of 16 to 39 participants.

4.3.3.4 Valuing protection own life and condom use

Another question wanted to find out if adolescents value the use of condoms to protect their life. Out of 119 study participants, 23 (19.33%) agreed and 82 (68.91%) totally agreed that adolescents use condoms to protect themselves from the risks of contracting HIV and AIDs and STIS. However, 7 (5.88%) study participants were neutral, 16 (19%) disagreed and 3 (3.36%) totally disagreed that adolescents valued the use condoms. The mean of study participants was 23.8 with standard deviation of 0.98 in the range of 4 to 82 participants.

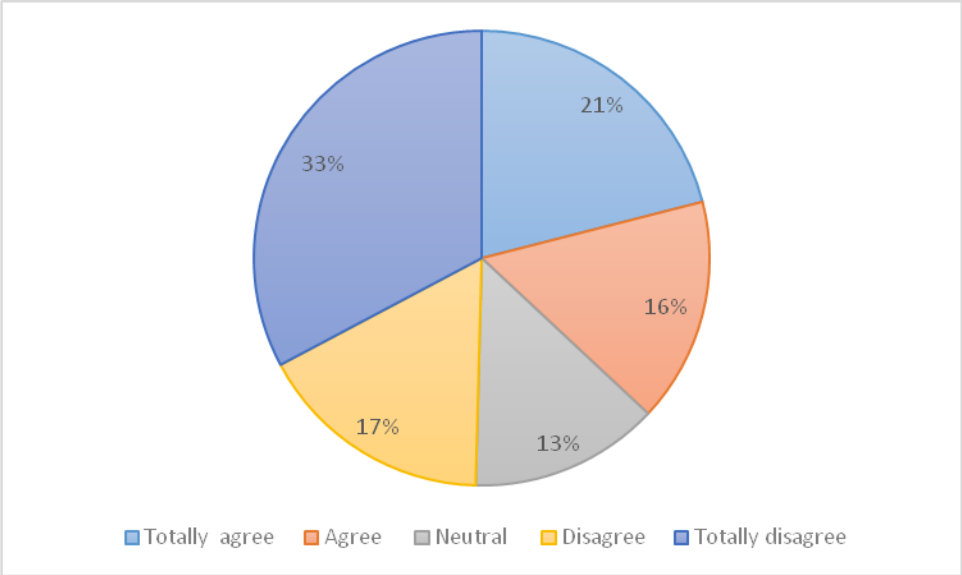

Figure 4: Respecting Family Values and Not Engaging in Sexual Practices

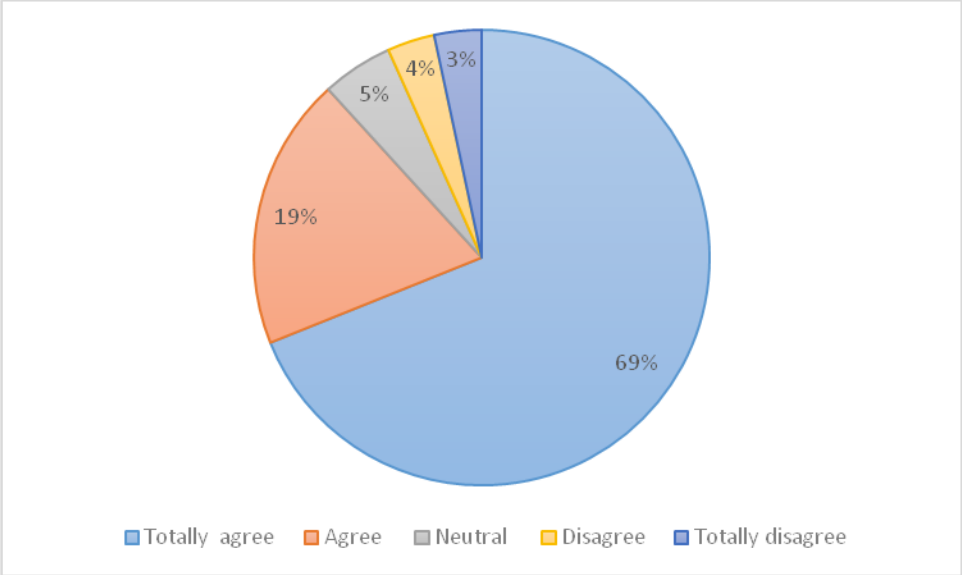

Figure 5: Valuing to Protect Own Life and Condom Use

4.3.3.5 Valuing pregnancy, HIV and STIs prevention and condom use

On whether participants valued condom use to prevent pregnancy, HIV and STIs, a number of participants 22 (18.49%) agreed and 83 (69.75%) totally agreed that they value condom use in order to prevent unintended pregnancies, HIV and STIs. The following are some of the statements that were expressed by participants:

We induce abortions using local concoctions which means that we do not need to become pregnant. In most cases these abortions give us health problems. Condoms are important since they prevent pregnancies that way we can be saved as girls (Study participant, 2019).

*Here in our District area girls get pregnant at a young age because we are not using condoms. I personally value using condoms when I am having sex. We need to realise how useful it is to use condoms especially those of us who engage in sexual practices (*Study participant, 2019*).*

The scale also shows that 7 (5.88%) study participants were neutral, 3 (2.52%) study participants disagreed and 4 (3.36%) totally disagreed that they value the use of condoms to prevent unintended pregnancies, HIV and STIs. The mean of study participants was 23.8 with standard deviation of 0.96 in the range of 3 to 83 participants.

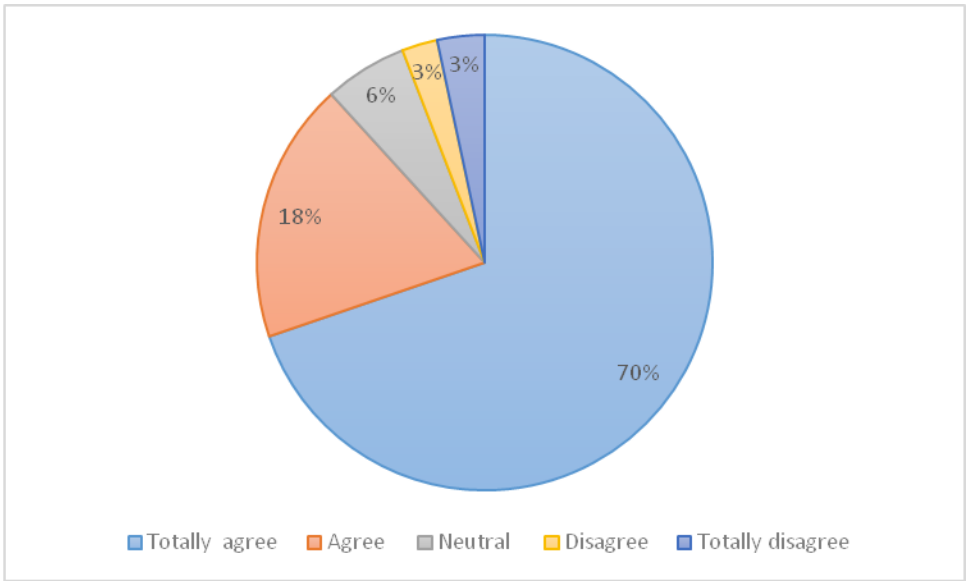

Figure 6: Valuing Pregnancy, HIV and STIs Prevention and Condom Use

4.3.3.6 Valuing sex partner's life and condom use

Another question sought to find out whether there are any adolescents who value sex partner's life and use of condoms to prevent infections that lead to disease. 26 (21.85%) participants agreed and 65 (54.62) totally agreed that they use condoms because they

value their sex partner's life. On the other hand, 11(9.24%) study participants were neutral, 11 (9.24%) disagreed and 6 (5.04%) totally disagreed that valuing sex partner's life influenced them to use condoms. The mean of study participants was 23.8 with standard deviation of 1.29 in the range of 6 to 65 participants.

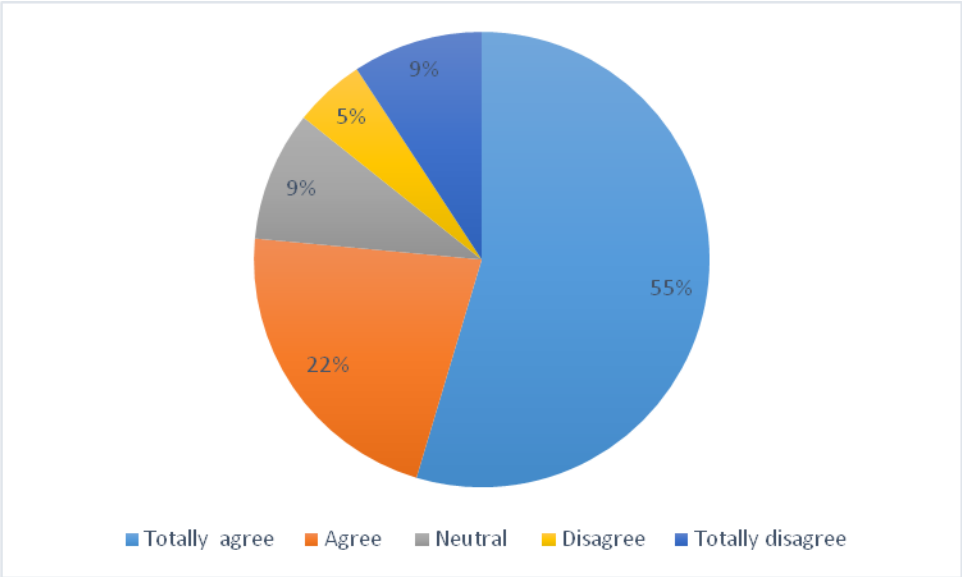

Figure 7: Valuing Sex Partner's Life and Condom Use

4.3.4 Adolescents' attitudes towards condom distribution in schools

Another question sought to identify attitudes which adolescent learners have towards condom distribution in secondary schools. Participants were required to affirm attitudes with focus on the strategy and develop an understanding whether these adolescents could personally or communally benefit from the approach. The findings have been presented in subsections in which percentages of particular attitudes towards condom distribution strategy of adolescents are outlined based on the level of agreement or disagreement on the likert scale. After explanatory presentation of results, corresponding bar graphs follow with percentages of the likert scale.

4.3.4.1 Pregnancy, HIV and STIS prevention in schools

Out of 119 participants, 19 (15.87%) agreed and 91 (76.47 %) totally agreed that condom distribution of condoms in secondary schools can help in the prevention of unintended pregnancies, HIV and STIs. When asked to express their attitudes towards condom distribution in schools, the following were the responses:

> *I strongly feel that making condoms available in secondary schools can yield better results especially in day schools. Teachers have no control over us when we are returning home, many of us have sexual relationships if I am to be honest. We usually have sex in the bushes when returning home after day classes or night studies. Normally, we do not prepare for sex but use any opportunity that arises and most of the times we do not have condoms where we risk pregnancies, HIV and STIs so having them around will give us easy access especially here in remote areas* (Study participant, 2019)

> *I have no problem having condoms in schools. I am not against the teachings of religion and culture but the truth is that sex happens amongst us adolescents. Within us, we have adolescents who were born with HIV and are equally sexually active. It is risky they might pass it on since we may not know who is HIV positive or negative. Making condoms available in schools is accepting that adolescents are equally at risk groups who need protection* (Study participant, 2019).

It is also shown that 2 (1.68%) participants were neutral, 1 (0.84 %) disagreed and 6 (5.04%) totally disagreed that condom distribution in schools can enhance prevention of unintended pregnancies, HIV and STIs. Their explanation was that "*there is still chance for pregnancies and infections among adolescents in school because condoms break. Some boys deliberately break the condom; this can still cause someone to be pregnant or contract HIV. Condoms are not a solution to our problems".*

The mean of study participants was 23.8 with standard deviation of 0.97 in the range of 1 to 91 participants.

4.3.4.2 Reduction of death due to unsafe abortions in schools

One question also sought to identify beliefs or attitudes towards condom distribution in schools in relation to reducing deaths that come due to unsafe abortions of school going

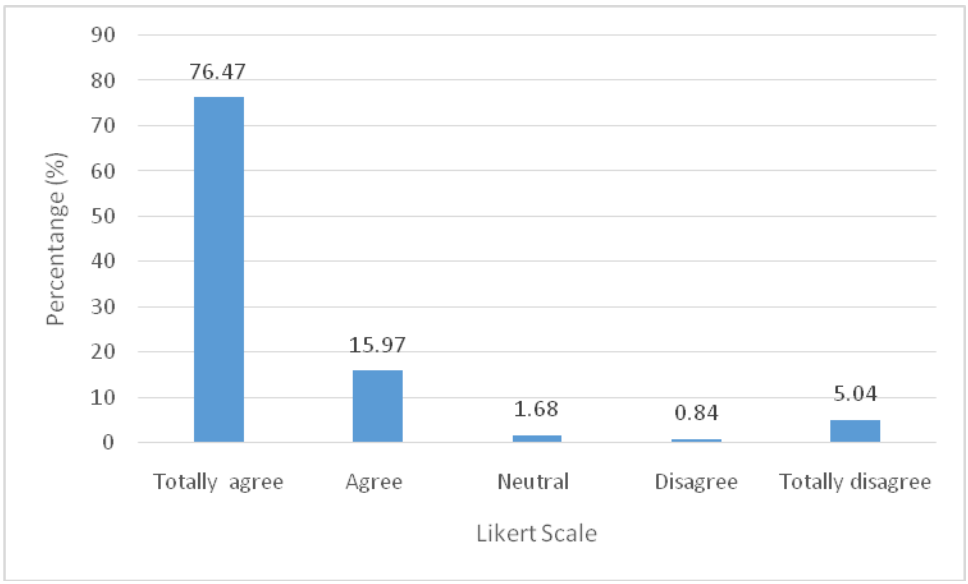

Figure 8: Pregnancy, HIV and STIS Prevention in Schools

adolescent girls. 62 (52.1 %) participants totally agreed to this view. In a slightly similar way, 46 (37.82%) participants also agreed to the belief. The lowest levels of the likert scale indicated that 8 (6.72%) of these participants were neutral on this belief while 2 (1.68%) disagreed and 2 (1.68%) totally disagreed. The mean of study participants was 23.8 with standard deviation of 0.82 in the range of 2 to 62 participants

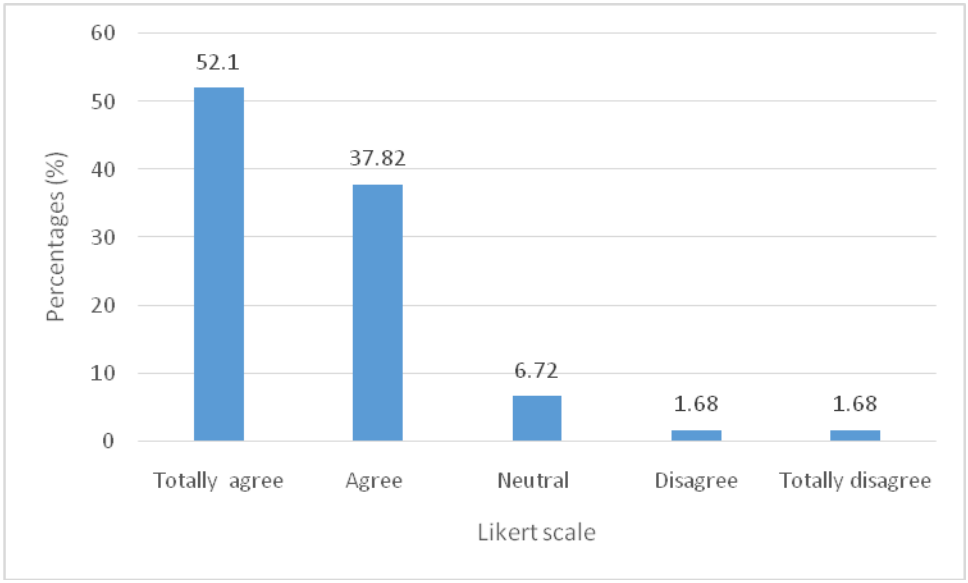

Figure 9: Reduction of Death Due to Unsafe Abortions in Schools

4.3.4.3 Increasing sexual immorality

Another question sought to establish if participants believe that condom distribution can increase sexual immorality. Out of 119, 32.77 % participants totally agreed that condom distribution in schools can increase sexual immorality among adolescents while 19 (15.97%) simply agreed. This study through interviews also observed reasons why some participants believe that condoms can increase sexual immorality in schools. Participants expressed statements such as:

> *When you give condoms to us it means you are telling us that go and have sex. It is true we develop sexual desires but we hold ourselves for fear of getting pregnant and being infected with diseases. Once we have condoms, we will have a feeling that we are protected and thereafter initiate sexual acts anyhow* (Study participant, 2019).

Furthermore, 27 (22.69%) were neutral, 13 (10.92%) disagreed, 21 (17. 65%) totally disagreed that distribution of condoms in schools can increase sexual immorality. The mean of study participants was 23.8 with standard deviation of 1.47 in the range of 13 to 39 participants.

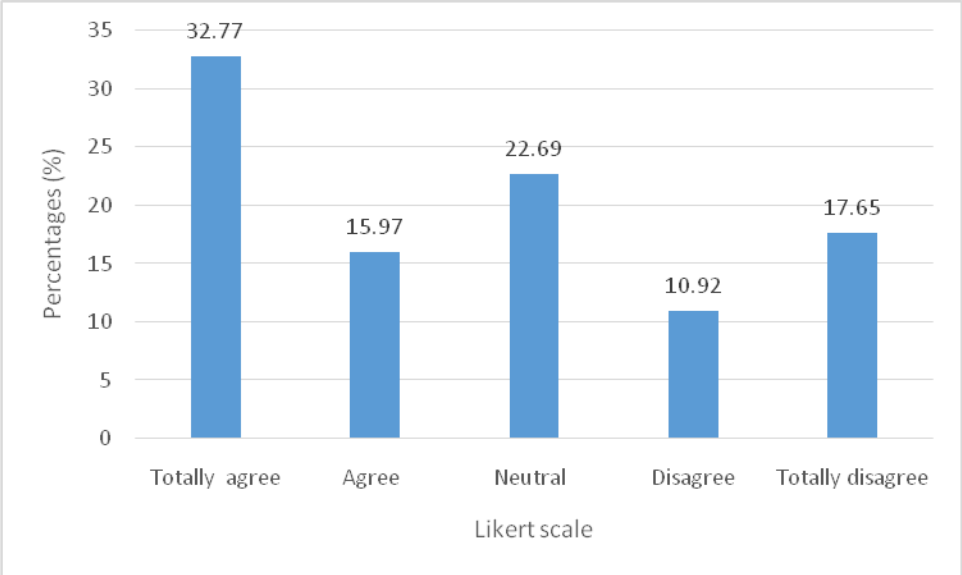

Figure 10: Increasing Sexual Immorality

4.3.4.3 Increasing condom access to students

Further, 44 (36.97%) participants totally agreed that secondary school based condom distribution strategy can increase access of condoms among adolescent students who cannot afford to buy condoms. Another 28 (23.53%) category of participants agreed to belief. However, 22 (18.49%) totally disagreed that the strategy can serve to increase accessibility of condoms among adolescents from poor families. 15 (12.61%) were neutral and 10 (8.4 %) participants did not agree to this belief. The mean of study participants was 23.8 with standard deviation of 1.51 in the range of 10 to 44 participants.

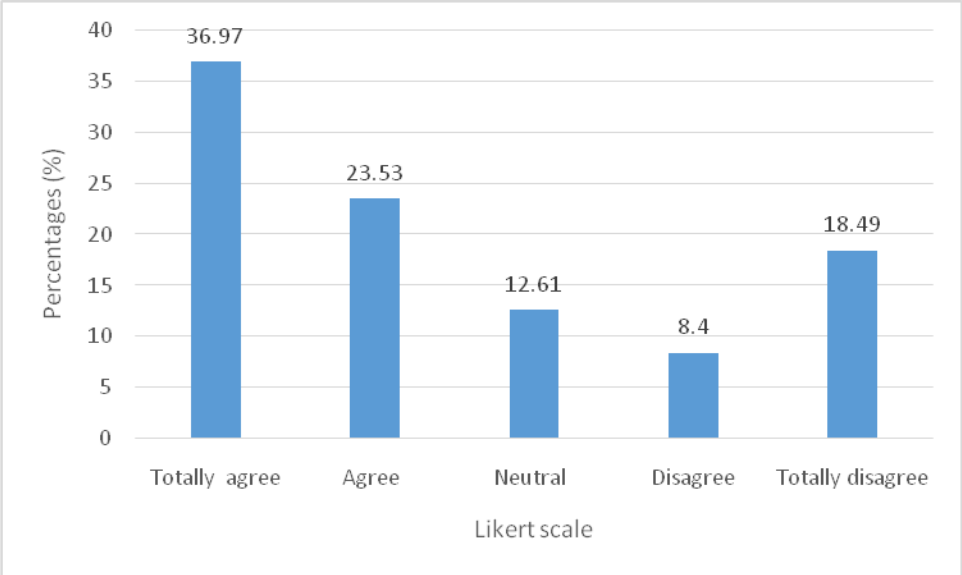

Figure 11: Increasing Condom Access to Students from Poor Families

4.3.4.4 Preventing adolescents from being stigmatised by condom sellers

One question sought to examine whether the condom distribution in secondary schools can help to prevent adolescents from being stigmatised by condom sellers. In line with this belief, 43 (36.13%) totally agreed that this approach can prevent adolescents from being stigmatised by shop owners when buying condoms. In addition, 38 (31.93%) agreed that this strategy can achieve the goal as stated in the question. Despite having the majority of the participants agreeing to the belief that condom distribution in secondary schools will help adolescents from being stigmatised, still 16 (13.45%) were neutral, 12 (10.08%) of the study participants disagreed and the other 10 (8.4%) totally disagreed to

the anticipated outcome of this approach. The mean of study participants was 23.8 with standard deviation of 1.27 in the range of 10 to 43 participants

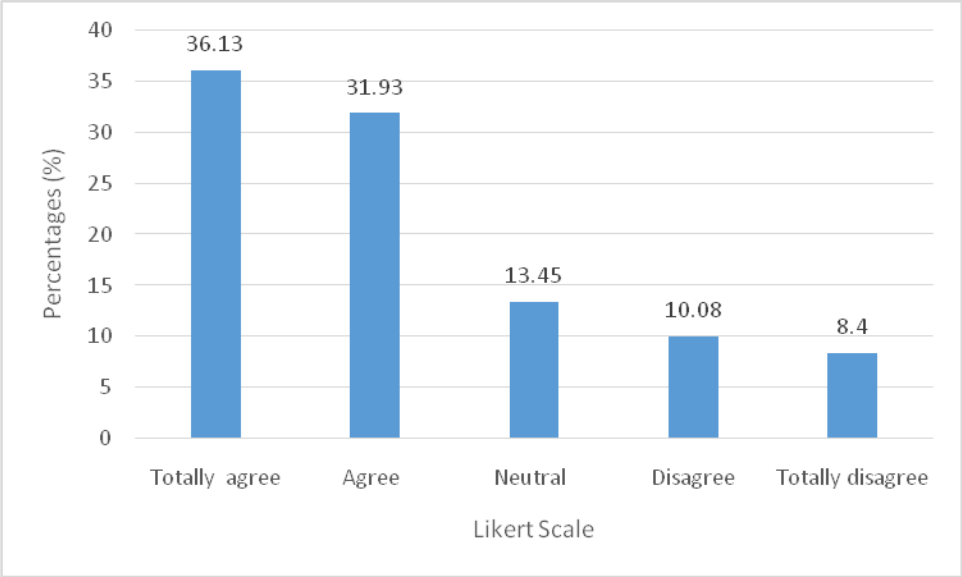

Figure 12: Preventing Adolescents from Being Stigmatised by Condom Sellers

4.3.4.5 Reducing distance to condom free access points

Another question sought to find out whether the distribution of condoms in schools reduce the distance to cover in order for adolescents to access condoms. 55 (46.22%) totally agreed while 36 (30.25%) agreed that the strategy can reduce the distance for sexually active adolescents in schools to go and access free condoms from the hospital and NGO's running condom distribution programs. On the other hand, 11 (9.24 %) of 119 participants were neutral, 9 (7.56%) disagreed and 8 (6.72%) totally disagreed. The mean of study participants was 23.8 with standard deviation of 1.23 in the range of 8 to 55 participants.

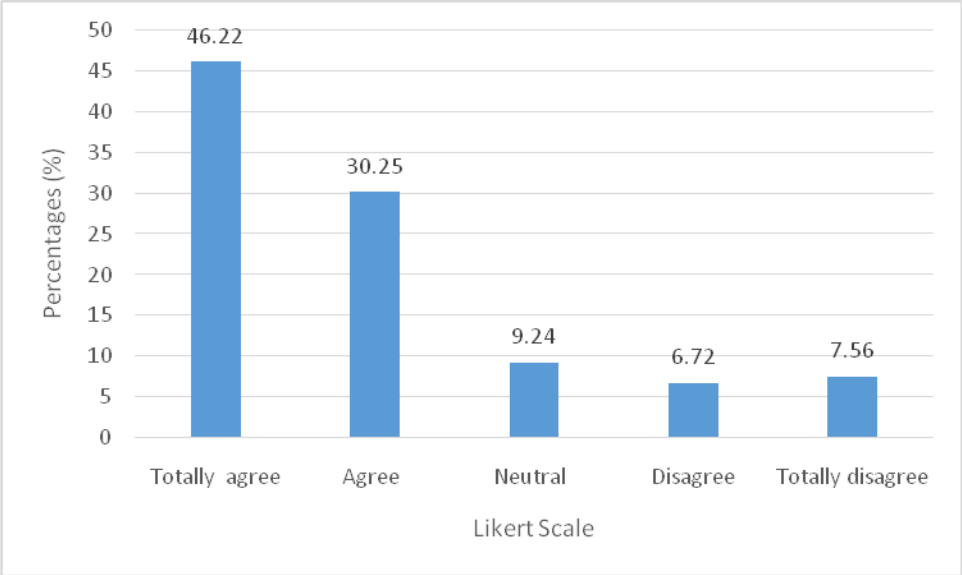

Figure 13: Reducing Distance to Condom Free Access Points

4.3.4.6 Affecting spiritual life of students

Another question intended to identify the attitudes that adolescent learners have towards school based condom distribution in relation to their spiritual life. Out of 119 participants, 40 (33.61%) totally agreed and 15 (12.61%) agreed that this approach can affect their spirituality. However, 25 (21.01%) participants totally disagreed that this can affect their spirituality. 20 (16.81%) of these study participants were neutral, that they were not certain as to whether this can affect their spiritual or not. The mean of study participants was 23.8 with standard deviation of 1.55 in the range of 15 to 40 participants.

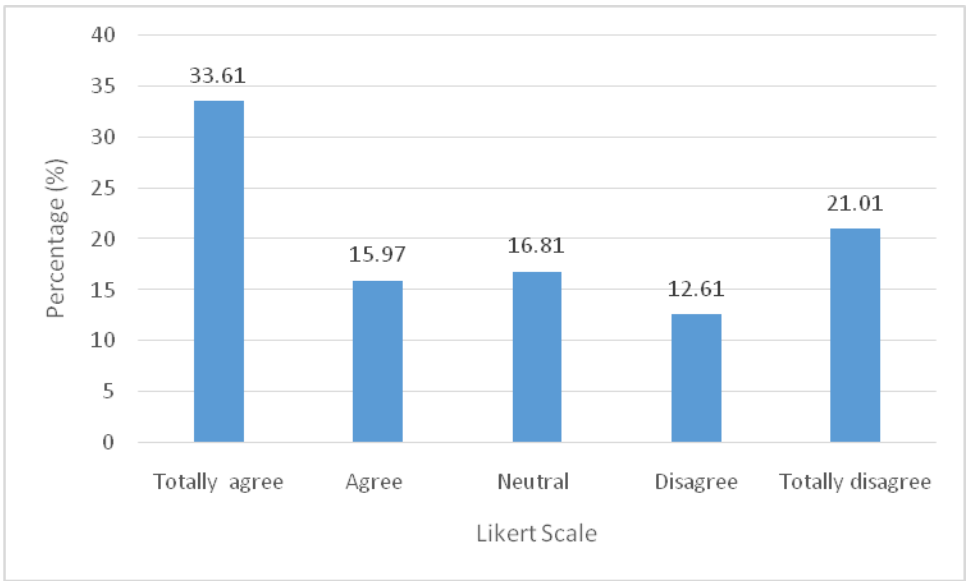

Figure 14: Affecting Spiritual Life of Students

4.3.4.7 Increasing awareness of condoms

On the belief that distributing condoms in schools is likely to increase awareness of condom use among sexually active adolescents, 78 (66.1%) participants totally agreed and 24 (20.34%) agreed. While the majority indicated in favor of the belief, 7 (5.9%) of the study participants were neutral. Further, 5 (4.24%) of these participants totally disagreed and 3 (2.54%) disagreed. The mean of study participants was 23.8 with standard deviation of 1.55 in the range of 3 to 78 participants

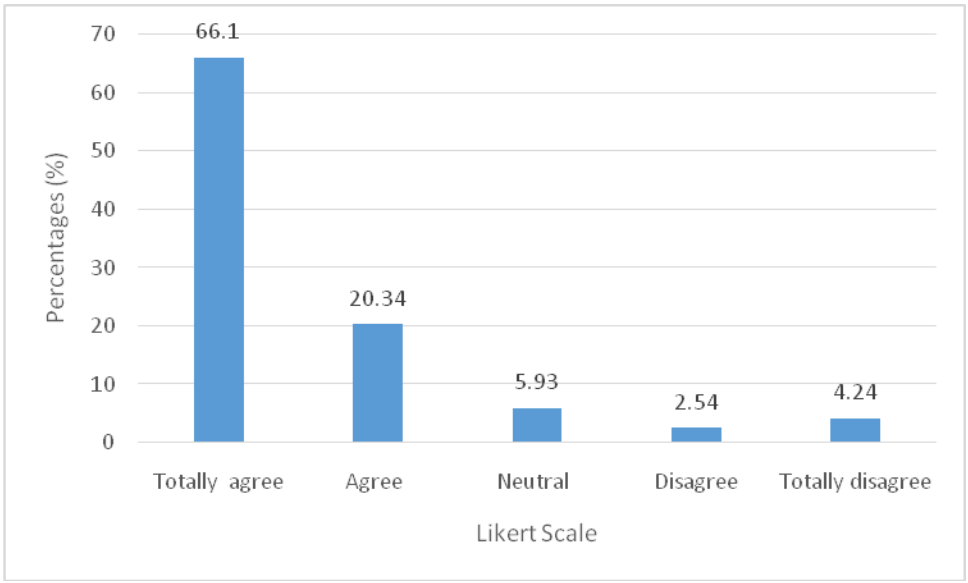

Figure 15: Increasing awareness of condoms

4.4 Inferential analysis

Kruskal Wallis analysis and Mann Whitney analysis were used to analyse various variables in relation to other variables. The analysis was undertaken to see if there are differences in levels of agreement among variables of different categories. Kruskal Wallis analysis was used on variables which had more than two categories while Mann Whitney analysis was used on variables that had two categories. In both types of analysis, if the p-value is less than 0.05, the conclusion is that there is a difference in levels of agreement in different likert scales, while if p-value is greater, then there is no difference.

4.4.1 Age with valuing condom use to protect sex partner's life

The analysis sought to see if there is a difference in responses of participants in different levels (likert scales) by focusing at the variable of age against valuing condom use to protect a sexual partner's life. The Kruskal – Wallis test was used since there are different age categories, ranging from 15 years to 19 years old. The p – value from the stata result was 0.03896 which is greater than 0.05 hence the null hypothesis that there is no difference in answering tendencies of participants from different degree levels is rejected. Therefore, there are differences in responses with most participants, under each age category, strongly agreeing to valuing the use of condoms to protect the sexual partner's life. This implies that age influences adolescents to agree with valuing condom use to protect the sexual partner's life.

Table 3: Age Range with Valuing Condom Use to Protect Sex Partner's Life

Age of respondent	I use condoms since I value my sexual partner's life				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
15 years	8	1	4	2	2
16 years	11	6	1	2	4
17 years	8	4	0	1	0
18 years	19	9	4	1	2
19 years	19	6	2	0	3

4.4.2 Age with valuing condom use to prevent unintended pregnancies, HIV and STIs

Another analysis sought to find out if there is a difference in answering tendencies of participants in different degree levels (likert scales) by focusing at the variable of age against valuing condom use to prevent pregnancies, HIV and STIs. The Kruskal – Wallis test was uses since age is in different categories. The p – value from the stata result was 0.042 which is less than 0.05 hence the null hypothesis that there is no difference in answering tendencies of participants from different degree levels is rejected. Therefore, there are differences in answering tendencies with most participants strongly agreeing with valuing condom use to prevent pregnancies, HIV and STIs. This implies that age influences adolescents to strongly agree with valuing condom use to prevent pregnancy, HIV and STIs.

Table 4: Age with Valuing Condom Use to Prevent Unintended Pregnancies, HIV and STIs

Age of respondent	I use condoms in order to prevent unintended pregnancies, HIV and STIs				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
15 years	9	4	3	1	0
16 years	13	7	1	1	2
17 years	9	4	0	0	0
18 years	29	3	1	1	1
19 years	23	4	2	0	1

4.4.3 Age with valuing condoms to protect own life

The analysis further sought to find out if there is a difference in answering tendencies of participants in different degree levels (likert scales) by focusing at the variable of age against valuing condoms to protect own life. The Kruskal – Wallis test was taken into consideration since age is in different categories. The p – value from the stata result was 0.04590 which is less than 0.05 hence the null hypothesis that there are differences in answering tendencies of participants from different degree level is rejected. Therefore,

there are differences in responses with most participants strongly agreeing with valuing condoms to protect own life. This implies that age influences adolescents to value distribution of condoms in order to protect own life.

Table 5: Age with Valuing Condoms to Protect Own Life

Age of respondent	I use condoms because I need to protect my life				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
15 years	10	4	1	1	1
16 years	14	7	2	1	0
17 years	11	1	0	1	0
18 years	24	8	1	1	1
19 years	23	3	2	0	2

4.4.4 Age with respecting religious values not to engage in sexual practice

Similarly, an analysis sought to find out if there is a difference in answering tendencies of participants in different degree levels (likert scales) by looking at the variable of age against respect for religious values of not engaging in premarital sexual practices. The Kruskal – Wallis test was used since age is in different categories. The p – value from the stata result was 0.1097 which is greater than 0.05 hence the null hypothesis that there is no difference in answering tendencies of participants from different degree levels is accepted. Therefore, there is no difference in responses in all degree levels. This implies that respecting religious values not to engage in premarital sexual practices has no relationship with age.

Table 6: Age with Respecting Religious Values Not to Engage in Sexual Practice

Age of respondent	I do not engage in sexual intercourse because I respect my religious values				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
15 years	3	5	5	2	2
16 years	14	0	2	4	4
17 years	1	2	5	3	2
18 years	8	5	1	9	12
19 years	9	2	3	5	11

4.4.5 Age with respecting culture and not engaging in sexual practices

The analysis sought also to find out if there is a difference in answering tendencies of participants in different degree levels (likert scales) by focusing at the variable of age against respect for culture not to engage in premarital sexual practices. The Kluskal – Wallis test was used since age is in more than two categories. The p – value from the stata result was 0.0031 which is less than 0.05 hence the null hypothesis that there is no difference in answering tendencies of participants from different degree levels is rejected. Therefore, there are differences in responses with most participants in all age categories strongly disagreeing with respect for culture not to engage in premarital sexual practices. This implies that age influences adolescents to value respect for culture not to engage in premarital sexual practices.

Table 7: Age with Respecting Culture Not Engaging in Sexual Practices

Age of respondent	I do not engage in sexual intercourse because I respect my cultural values				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
15 years	1	4	7	3	2
16 years	5	5	2	8	4
17 years	2	2	2	7	0
18 years	2	6	1	11	15
19 years	1	2	5	9	13

4.4.6 Residence with reducing distance to free condom access points

The analysis also sought to find out if there is a difference in answering tendencies of participants in different degree levels (likert scales) by focusing on the variable of residence against the attitude of reducing distance to free condom access points. The Mann – Whitney test was used since residence is in two categories, namely, urban and rural. The p – value from the stata result was 0.0056 which is less than 0.05 hence the null hypothesis that there is no difference in answering tendencies of participants from different degree levels is rejected. Therefore, there are differences in responses with most participants from both groups of residence strongly agreeing to the attitude. This implies that the attitude that distributing condom in schools can reduce distance to free condom access points is the same in both rural and urban settings.

Table 8: Residence with an Attitude of Reducing Distance to Free Condom Access Point

Residence of respondent	School based condom distribution can reduce distance for adolescents to hospital				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
Urban	31	15	6	3	6
Rural	24	21	5	5	3

4.4.7 Religion and increasing sexual immorality

Further, the analysis sought to find out if there is a difference in answering tendencies of participants in different degree levels (likert scales) by focusing at the variable of religion against the attitude of increasing sexual immorality. The Mann – Whitney test was used since religion is in two categories, namely, Muslims and Christians. The p – value from the stata result was 0.1473 which is less than 0.05 hence the null hypothesis that there is no difference in answering tendencies of participants from different degree levels is accepted. Therefore, there is no difference in responses in both categories. This implies that the increase of sexual immorality among adolescents has no relationship with religion.

Table 9: Religion with Increasing Sexual Immorality

Religion of respondent	School based condom distribution can promote sexual immorality				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
Christianity	28	14	16	6	13
Islam	11	5	11	7	8

4.4.8 Gender with preventing pregnancies, HIV and STIs

The analysis also sought to find out if there is a difference in answering tendencies of participants in different degree levels (likert scales) by focusing at the variable of gender against valuing condom use to prevent pregnancies, HIV and STIs. The Mann – Whitney test was taken into consideration since residence is in two groups, namely, urban and rural. The p – value from the stata result was 0.035 which is less than 0.05 hence the null hypothesis that there is no difference in answering tendencies of participants from different degree level is rejected. Therefore, there are differences in responses with most participants from both gender strongly agreeing with the value. This implies that both gender categories strongly agree with the attitude of valuing condom use to prevent pregnancies, HIV and STIs.

Table 10: Gender with Preventing Pregnancies, HIV and STIs

Gender of the respondent	I use condoms in order to prevent unintended pregnancies, HIV and STIs					
	Totally agree	Agree	Neutral	Disagree	Totally disagree	
Male	40	12	2	1	3	
Female	43	10	4	2	1	

4.4.9 Age with affecting spirituality of students

The analysis also sought to find out if there is a difference in answering tendencies of participants in different degree levels (likert scales) by focusing at the variable of age against the belief that distributing condoms in school can affect the spirituality of students. The Kluskal – Wallis test was used since age is in different categories ranging from 15 to 19 years old. The p – value from the stata result was 0.8189 which is greater than 0.05 hence the null hypothesis that there is no difference in answering tendencies of participants from different degree levels is accepted. Therefore, there is no difference in responses in all degree levels from all age categories. This implies that the attitude that distributing condom in schools can affect the spirituality of students is the same among adolescents of all ages.

Table 11: Age with Affecting Spirituality of Students

Age of respondent	School based condom distribution can affect our spiritual life				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
15 years	4	1	6	3	3
16 years	7	8	4	3	2
17 years	5	1	1	3	3
18 years	15	3	3	5	9
19 years	9	6	6	1	8

4.5 Summary

This chapter has presented the data collected from eight key informants and 119 study participants. The data has been presented following specific themes. Where necessary, direct quotes from key informants and focus group discussions have been included in the presentation. Further, the data from the study participants was presented in form of numeric figures and percentages using tables, pie charts and graphs.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings of the study. It traces the general values and attitudes towards condom distribution. It also discusses health benefits oriented values and attitudes.

5.2 Values and attitudes towards condom distribution and population health

The results of adolescent learners' attitudes show that out of 119 participants, 91 (76.47 %) totally agree and 19 (15.87%) agree that condom distribution in secondary schools can help to prevent unintended pregnancies, HIV and STIs. Some study participants explained that the availability of condoms in secondary schools can reduce the risk of HIV transmission. The results indicate also that adolescents engage in unprotected sex in nearby bushes after day and/or night studies.

The results also show that 83 (69.75%) totally agreed and 22 (18.49%) agreed that they value condom use in order to prevent unintended pregnancies, HIV and STIs. The results also show that girls value condoms as a mean of averting health problems that come due to failure of traditional concoctions that are used to conduct abortions. This is in line with established evidence that positive values and attitudes towards condom use and distribution among adolescents are key to achieving adolescent sexual and reproductive health while values that do not recognise sex outside marriage compromise the sexual and reproductive health of adolescents in America (Schalet et al. ,2017).

The results agree with the utilitarian theory. Utilitarianism, based on the works of Jeremy Bentham, considers the right choice to be the one that produces "the greatest happiness of

the greatest number (Bentham, 1955). Utilitarianism rejects absolute application of moral codes but rather clarifies and interprets how these standards should be applied on a moral issue (Galmund, 2000). The results show that most of the adolescent learners have values and attitudes which are more in favour of condom distribution in schools than the values and attitudes promoting abstinence. Public health focuses on community and population interests which lead to the tension between the rights of individuals and the interests of the community; the core conflict of public health ethics (Mastroianni, 2014). Therefore, the utilitarian theory provides an ideal situation for maximizing the interests of the community.

5.3 Health benefits oriented values and attitudes

To explore values and attitudes of stakeholders towards condom distribution among adolescent learners in secondary schools, stakeholders implementing the condom distribution policy and programs were asked to state the aim of their activities, while others including students were asked to express their views towards these programs. The other objective assessed the effect of stakeholders' values and attitudes towards HIV, STIs and pregnancy.

This study shows that there are significant differences in values and attitudes towards condom distribution among adolescents, and responses were based on interventions and moral beliefs. The results from key informants from the health sector and school condom distribution programs implementers show that the whole purpose of condom distribution among adolescents is to protect adolescents from harm caused by unprotected sex. On the other hand, the key informants from the education sector and religious leaders reject condom distribution among adolescents in order to promote abstinence and preserve the virginity of adolescents. The results of this study are consistent with the report from one study conducted in Zambia on stakeholder's perspectives on condom promotion in schools. The study showed that some stakeholders supported condom promotion in schools to prevent high HIV infections among young people while religious leaders insisted that young people should abstain from sex (Kamanga, 2018).

These findings can be examined in line with common morality ethical theory which puts much emphasis on the determination of the ideal fit between competing values in ethical decision making. Common morality is, therefore, the moral system that thoughtful people use, usually implicitly, when they make moral decisions and judgments and it is the only guide to behaviour affecting others that all rational persons understand and upon which they can all agree (Gert, 2004). Olaru (2010), argues that ethical decision making should start from these common experiences and identify the principles or values liable to be recognised as widely as possible, and should not proceed from an abstract level down to concrete cases.

In this study, the effects of stakeholders' values and attitudes towards HIV, STIs and pregnancy were also considered to trace evidence on which examination of the competing values and attitudes should be undertaken using common morality. The results show that sexual activities take place among adolescents based on follow ups of clients by health practitioners and condom distribution program implementers. This study established that there was adolescent maternal death, attempted unsafe abortions and pregnancy of an adolescent reactive girl. Gert (2004) believes harms motivate rational persons for goods or benefits. Harms can be classified as death, pain, disability, loss of freedom and loss of pleasure (Daly, 2014). According to this theory, preventing harm is ideal over all other values. Thus, if condom distribution to adolescents in schools save students from harm caused by unprotected sex, then it is morally permissible, just as abstinence is if adhered to by adolescents in schools.

Beauchamp and Childress account for beneficence ethical principle that health professionals have obligations to provide benefits to patients or others which involves protection of individual welfare and promotion of common welfare (Daly, 2014). Gostin and Powers (2006) assert that public health care providers have an obligation to address root causes of ill-health. Both Beauchamp and Gert assert that beneficent acts are universally acceptable because they seek to prevent the harms. In line with the results of this study, both public health practitioners and other stakeholders implementing condom

distribution in secondary schools are justified based on the value of providing health benefits, and preventing harm, through the provision of condoms.

However, beneficence principal and common morality only justify values and attitudes towards condom distribution to adolescent learners but do not deal with practical aspects of the intervention especially when values and attitudes meant to reach the same goal come into conflict. Public health policies, intervention and programs should intend to achieve public goals of reducing morbidity or mortality (Kass, 2005).

The results show that both the condom distribution policy and program's values and attitudes aim at preventing harm. In the same vein, values of religious leaders and key informants from the education sector have an inherent capacity to reduce morbidity and mortality. However, there are some challenges with each direction. For example, the use of condoms is faced by challenges that may defeat the purpose of condoms. First, condoms can break during sex, or adolescents can break the condom purposively during sex which can lead to infections and/or pregnancy. On the other hand, the rejection of condoms to promote abstinence does not always yield results because there is evidence that adolescents engage themselves in sex.

According to Kass (2001), when the conflict of values compromises the public health goals, public health goals should respond to the following questions: can burdens be minimised? Are there alternative approaches? Disagreements are inevitable and decisions must be reached through a system of fair procedures. The society needs to engage in a democratic process to determine which public health functions should be maintained while recognizing both avoidable and unavoidable liberty infringements and other burdens (Kass, 2005, p. 245). This way provides a platform for dialogue on values and attitudes towards condom distribution in order to achieve positive health outcomes of the adolescents.

5.4 Summary

This chapter examined values and attitudes towards condom distribution among adolescent learners. The discussion was conducted in three series; under utilitarian ethical theory, non-deductive ethical principle, and practice based ethics framework. The utilitarian theory was used to examine study results in relation to the interest of the largest number. In addition, beneficence ethical principle was applied to help understand the reasons which can guide ethical decisions in public health. Finally, Nancy Kass' six-part ethics implication framework was used to explain ethical implications which public health practitioners should take into account when implementing public programs such as condom distribution in secondary schools.

CHAPTER SIX

CONCLUSION AND IMPLICATIONS

6.1 Introduction

The main objective of this study was to examine values and attitudes towards condom distribution to adolescent learners in secondary schools in Nkhotakota, Malawi. This chapter offers the conclusion of the study. It presents a summary and implications of the findings.

6.2 Summary of findings

The study revealed that most adolescent learners have positive values and attitudes towards condom distribution in secondary schools. This suggests that the values and attitudes of adolescents can help to improve adolescent sexual and reproductive health especially when their values are considered in the development of sexual health policies and programs. The study also showed that out of 119 participants, 91 (76.47 %) totally agreed and 19 (15.87%) agreed that condom distribution in secondary schools can help in the prevention of unintended pregnancies, HIV and STIs.

The study also showed that there are significant differences in values and attitudes towards condom distribution among adolescents. Results indicate that stakeholders responded differently by giving varied reasons based on their values and attitudes. However, the study examined these values and attitudes and made a conclusion that the reason for morality should be to avoid harm for oneself or another person, and also public health and medical health practitioners should at all cost work to prevent harm on individuals and the community. It is therefore important to incorporate such theoretical framework into public health policies and program development.

Regardless of all the benefits of the different values and attitudes, there are some challenges associated with each approach, thus harm prevention by the health sector and

abstinence by the education sector and religious leaders. The challenges include failure of adolescents to use condoms properly and persistent sexual health problems among adolescents while upholding the value of abstinence. Therefore, this study suggests that there should be stakeholder engagement in order to minimise some health burdens associated with each direction.

6.3 Implications

The study found that most values and attitudes of adolescent were more favorable to condom distribution in secondary schools. Therefore, this study makes an assumption that if high number of adolescents engage in sex while in school, the application of utilitarian theory on these values and attitudes towards condom distribution in secondary school can help to prevent pregnancies, unsafe abortions and rapid transmission of STIs and HIV among adolescents.

It was also discovered that religious leaders and key informants from the education sector had values and attitudes which were opposed to condom distribution to adolescents in secondary school. Given the evidence of sexual acts among adolescents in schools, sticking to abstinence approach only can compromise sexual and reproductive health of adolescents in secondary school.

6.4 Suggested future research

The researcher suggests that, since this study was conducted using small sample size so it is difficult to generalize the meaning of the results. There is a need to have a similar study conducted in all the three regions of Malawi in order to determine if the results findings in this study can be attributable to all regions.

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APPENDICES

Appendix 1: A Questionnaire for Study Participants

Chancellor College

Philosophy Department

Master of Arts in Applied Ethics

Research title: Examining Stakeholders' Values and Attitudes towards Condom Distribution to Adolescent Learners in Secondary School in Nkhotakota, Malawi.

- May you please provide your views and opinions on your knowledge, values, attitudes and beliefs on condom distribution to adolescent learners in secondary schools?
- You are advised **NOT** to write your name or any identification on this paper
- All the information given in this questionnaire will be treated as private and will be used for academic purposes only

SECTION A

Firstly, you will reply to questions about your general information.

1. Gender

a. Male

b. Female

2. Age

a. 15 years old

b. 16 years old

c. 17 years old

d. 18 years old

e. 19 years old

3. Class

a. Form one

b. Form two

c. Form three

d. Form four

4. Religion?

a. Christianity

b. Islam

c. Non believer

d. None of the above

5. Location

a. Urban

b. Rural

SECTION B

Instructions:

You are requested to respond to each item by indicating how true the statement is based on your feeling, using a 5 point likert scale as indicated below.

a. Strongly agree

b. Agree

c. Neutral

d. Disagree

e. Strongly disagree

Secondly, you will reply to questions concerning ways which increase your knowledge about your sexual health and condom use.

6. Life skills lessons by teachers.

a. Strongly agree

b. Agree

c. Neutral

d. Disagree

e. Strongly disagree

7. Open communication with parents.

a. Strongly agree

b. Agree

c. Neutral

d. Disagree

e. Strongly disagree

8. Open communication with friends.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

9. Through radio and television programs.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

10. Open communication with sexual partner.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

11. Advice from our youth club.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

12. Information from the billboards.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

13. Message from songs and music.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

14. Advice from community counselors.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

15. Information from the hospital.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

16. Through public awareness campaign by NGOs.
    a. Strongly agree
    b. Agree

c. Neutral
d. Disagree
e. Strongly disagree

Thirdly, you will reply to questions concerning the values that affect your sexual behavior and use of condoms.

17. Religious values restrain me from sexual activities.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

18. My religion values condom use.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

19. My community's values restrain me from sexual activities.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

20. My community's values influence me to engage in sexual activities.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

21. My community values condom use.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

22. My family values restrain me from sexual activities.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

23. Family values condom use.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

24. I do use condoms because I value my life.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree
25. I use condoms to prevent unwanted pregnancies.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

26. I use condoms because I value my partner's health and life.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

Fourthly, you will reply to questions concerning your attitudes and Beliefs toward condom availability in secondary schools. Condom availability in schools can……

27. Increase prevention of rapid transmission of HIV and STIs and unwanted pregnancies.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

28. Prevent deaths of adolescent girls due to unsafe abortions.
    e. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

29. Increase sexual activities in schools.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

30. Increase access of condoms to poor students.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

31. Prevention of stigma from shopkeepers.
    a. Strongly agree

b. Agree
c. Neutral
d. Disagree
e. Strongly disagree

32. Increase privacy from other buyers.
a. Strongly agree
b. Agree
c. Neutral
d. Disagree
e. Strongly disagree

33. Reduce distance to youth friendly services at hospital and NGOs.
a. Strongly agree
b. Agree
c. Neutral
d. Disagree
e. Strongly disagree

34. Reduce sexual pleasure.
a. Strongly agree
b. Agree
c. Neutral
d. Disagree
e. Strongly disagree

35. Compromise students' spiritual life.
a. Strongly agree
b. Agree
c. Neutral
d. Disagree
e. Strongly Disagree

36. Increase awareness of condom use and sexual health.
a. Strongly agree
b. Agree
c. Neutral
d. Disagree
e. Strongly disagree

Appendix 2: In-depth Interview Guide Form

Chancellor College

Philosophy Department

Master of Arts in Applied Ethics

INTERVIEW GUIDE FOR CONDOM INTERVENTION SERVICE PROVIDERS VALUES AND ATTITUDES TOWARDS CONDOM DISTRIBUTION TOADOLESCENTS IN SECONDARY SCHOOLS.

Examining Stakeholders' Values and Attitudes towards Condom Distribution to Adolescent Learners in Secondary School in Nkhotakota, Malawi.

1. Name of the organization.
2. When did you start implementing youth friendly services for instance distributing condoms to the youth?
3. What was the aim behind initiating and implementing this project? Describe values attached to the project.
4. Who are your main clients? Describe their age range, setting and sex.
5. What achievements has this project made since it was implemented?
6. Do you ever serve adolescents from secondary schools?
7. What are the opportunities and challenges for adolescents in accessing condoms here? Explain your answer.
8. Doesn't distributing condoms to young adolescents contribute to increased sexual immorality?
9. Do you have confidence in abstinence only results in adolescent sexuality? Explain your answer.
10. How do you balance your approach with the community's cultural and religious adolescent sexuality teachings? Explain your answer.

Appendix 3: In-depth Interview Guide Form

Chancellor College

Philosophy Department

Master of Arts in Applied Ethics

INTERVIEW GUIDE FOR POLICY VALUES ON CONDOM DISTRIBUTION TO SECONDARY SCHOOL LEARNERS

a. Ministry of health

1. Name of the ministry
2. When did the program of distributing condoms to adolescents in secondary schools in Malawi start?
3. What are the factors that motivated the ministry to take this approach?
4. What are the benefits of this program?
5. What challenges does this program face?
6. Did the program consider issues of sexual morality in adolescents in secondary schools?
7. Are there reports on how this approach is helping adolescents achieve their sexual and reproductive health?

b. Ministry of education

1. What do you know about condom distribution in schools?
2. How does distributing condoms to adolescents in secondary school conflict with your adolescent sexual and reproductive health policies?
3. What is the meeting point of your education policy on adolescent sexual health and that of the MOH?
4. What are the benefits of your adolescent sexual and reproductive policies over condom distribution to learners in secondary schools?
5. What are the challenges that can come along distribution of condoms to learners in secondary school?

Appendix 4: In-depth Interview Guide Form

Chancellor College

Philosophy Department

Master of Arts in Applied Ethics

INTERVIEW GUIDE FOR RELIGIOUS LEADERS' VIEWS ON CONDOM DISTRIBUTION TO ADOLESCENTS IN SECONDARY SCHOOL AND HOW THESE VIEWS CAN AFFECT ACCESS OF CONDOMS BY ADOLESCCENTS (Pastor and Sheik).

What do you know about condom use?

Do you know anything regarding condom distribution to adolescent learners in schools?

3. If yes, what are your views concerning distributing condoms to adolescents in secondary schools as a way of preventing HIV, STIs and unwanted pregnancies.
4. Are there situations where you meet pregnant or sexually infected adolescent learners within your religious setting? If yes, how do you handle such issues?
5. Is there any intervention that you put in place for preventing adolescent learners from getting early pregnancies and contracting HIV and other Sexually Transmitted infections? If there is any in line with question (5), explain why your suggested intervention is reliable?
7. How do you prepare adolescents particularly in secondary schools to prevent HIV, STIs and unwanted pregnancie

Appendix 5: In-depth Interview Guide Form

Chancellor College

Philosophy Department

Master of Arts in Applied Ethics

INTERVIEW GUIDE FOR HEADTEACHERS' VIEWS ON CONDOM DISTRIBUTIONTO ADOLESCENTS IN SECONDARY SCHOOL AND HOW THESE VIEWS CAN AFFECT ACCESS OF CONDOMS BY ADOLESCCENTS.

1. What do you know about condom use?
2. Do you know anything regarding condom distribution to adolescent learners in schools?
3. If yes as for question (2), what are your views concerning distributing condoms to adolescents in secondary school? Can this be effective way of preventing HIV, STIs and unwanted pregnancies among adolescents?
4. What opportunities or challenges can this strategy have if it was implemented?
5. Are you aware of the education policy and how it describes promotion of adolescent health?
6. Is there any intervention that you put in place for preventing adolescent learners from getting early pregnancies and contracting HIV and other Sexually Transmitted infections?
7. If there is any in line with question (5), explain why your suggested intervention is reliable?
8. How do you as a school treat adolescent learners found in possession of condoms?

Appendix 6: Informed Consent

Chancellor College

Philosophy Department

Master of Arts in Applied Ethics

Title of Project: Condom Distribution to Adolescent learners in Nkhotakota, Malawi: An Ethical Evaluation.

Principal investigator	Research Supervisor
Manly Mkonda Phiri	Dr. Vincent Jumbe
Chancellor College	College of Medicine
Private Bag 280	Private Bag 360
Zomba, Malawi	Chichiri, Blantyre 3
Cell: (+265)0999180	Cell: (+265)0888310655

Informed Consent Form

What you need to know about this study

This is an academic research being conducted by **Manly Mkonda Phiri**, a student for **Masters in Applied Ethics at Chancellor College of the University of Malawi**. It is the requirement of the Program to have this research study done for the partial fulfillment for the award of the Masters' Degree. Your participation in this study is solely voluntary. The study is self-sponsored.

Purpose of the Study: The purpose of this study is to look at condom distribution to adolescent learners in secondary schools. It also seeks to ethically evaluate condom distribution to learners in Malawi. Data will be analysed using ethical theories will help recommend significant approaches towards achieving adolescent sexual and reproductive health in Malawi.

What will be done? You will complete a questionnaire, which will take 40 minutes. The questionnaire will include questions concerning knowledge, values, attitudes and beliefs of different stakeholders about or towards condom distribution to adolescent learners in Malawi. It will also include questions about the history of condom distribution in schools in Malawi and factors that affect condom accessibility to adolescent learners.

Benefits of this Study: You will be contributing to knowledge about ethics in public health programs and projects.

Risks or discomforts: No risks or discomforts are anticipated from taking part in this study. But if you feel uncomfortable with a question, you can skip that question or withdraw from the study altogether. If you decide to quit at any time before you have finished the questionnaire, your answers will NOT be recorded.

Confidentiality: Your responses will be kept completely confidential. Each participant will be assigned a participation number, and only the participant number will appear with your responses. Only the researcher will see your individual responses. The responses will be securely kept within the Department of Philosophy's premises for some time before they are destroyed.

Decision to quit at any time: Your participation is voluntary; you are free to withdraw your participation from this study at any time. You also may choose to skip any questions that you do not wish to answer.

How the findings will be used: The results of the study will be used for scholarly purposes only. The results from the study will be presented in educational settings and at professional conferences, and the results might be published in a professional journal.

Contact information: If you have concerns or questions about this study, please contact the Head - Department of Philosophy, Dr Yamikani Ndasauka by email: yndasauka@cc.ac.mw or phone: +265 99 74 67 877; or Postgraduate Coordinator, Dr. Simon M. Makwinja by email: smakwinja@cc.ac.mw or phone: +265 99 12 14 677.

I……. acknowledge that I have read this information and agree to participate in this research on ……..

Appendix 7: Introduction Letter

PRINCIPALCHANCELLOR COLLEGE Prof. Richard Tambulasi, B.A (Pub Admin), BPA (Hons), MPA, Ph.D P.O. Box 280, Zomba, Malawi

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Our Ref: MA/PHIL/19/02/2019

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Your Ref

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19th February, 2019.

TO WHOM IT MAY CONCERN

INTRODUCTION LETTER: MANLY MKONDA

This serves to introduce **Manly Mkonda,** a student registered with the University of Malawi, Chancellor College pursuing Master of Arts in Applied Ethics.

As a requirement for graduating, he is supposed to conduct research leading to a dissertation. The title of the research he is conducting is Condom Distribution to Adolescent Learners in Secondary School in Nkhotakota, Malawi: An Ethical Evaluation.

As part of his research, Manly will be required to collect empirical data. Data collection tools have been vetted by the Department of Philosophy and they have been deemed to adhere to ethical standards. In addition research findings will be used for academic purposes and to inform policy only.

Assistance rendered to him will be highly appreciated.

If you have any question on his research or reports of unethical standards during his data collection process please do not hesitate to contact the undersigned on mobile phone +265997467877 or email yndasauka@cc.ac.mw or the Postgraduate coordinator,

Department of Philosophy on mobile phone +265991214677 or email smakwinja@cc.ac.mw.

Yours sincerely,

DR. Y. NDASAUKA HEAD OF PHILOSOPHY DEPARTMENT

Cc: Dean of Humanities, Dean of Postgraduate Studies, Dr Vincent Jumbe (supervisor)