BREAKING THE SILENCE: SEXUAL REPRODUCTIVE HEALTH AS A CHALLENGE AND OPPORTUNITY FOR YOUTH MINISTRY IN THE CHURCH OF CENTRAL AFRICA PRESBYTERIAN (CCAP) SYNOD OF LIVINGSTONIA

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DECLARATION

By this thesis electronic submission, I declare that the entire work contained there is my own original work, and that I am the sole author (unless to the extent explicitly otherwise stated). Any publication or reproduction by Stellenbosch University will not infringe any third-party rights and I have not previously in its entirety or in part submitted it for obtaining any qualification.

ABSTRACT

The study was motivated by the increased prevalence of unwanted pregnancies, early marriages, unsafe abortions, and school dropouts among the youth due to a lack of Sexual Reproductive Health (SRH) knowledge. The aim of the study was to explore and establish whether the Church of Central Africa Presbyterian (CCAP) is silent on issues of SRH, and if so, how the Synod can break the silence.

This study investigated how the CCAP Synod of Livingstonia can engage theological concepts to break the silence on SRH as a challenge or opportunity for youth ministry. The study focused on human dignity as the main theological concept that pays attention to the image of God (imago dei). The theological concept of human dignity focused on some attributes of the image of God, such as inviolability among others. Every human being, in the image of God, should be able to exercise their rights. It further explored how the church must consider SRH services as part of holistic ministry.

The literature studied further indicated that there are some SRH determinants such as social and cultural behaviours, social-religious beliefs, and poor health facilities. The empirical research was conducted within the CCAP catchment area where the interviewees were either church elders, church ministers, or youth. Usingin-depth semi-structured interviews and focus group discussions, the views and opinions of those participants mentioned above were gathered. The data was analyzed using thematic analysis, and subjected to theological interpretations.

The study findings showed that Synod had an SRH policy in place. However, that policy had not been implemented since the package of SRH contradicts its church doctrines that emphasize abstinence among the youth. Further, findings indicated that the church was not doing much to promote SRH among the youth because should the Synod be engaged in SRH issues, it might be seen as promoting immorality among the youth.

Nonetheless, almost all respondents accepted that individuals are aware of the importance and appreciate the package in SRH as it will be able to protect the youth from the consequences of lack of SRH. The findings further confirmed that the church had witnessed youth being suspended due to unwanted pregnancies despite continuous preaching of abstinence. One of the worst scenarios mentioned by participants was the deaths of young women in the church suspected to have died from complications of unsafe abortions. However, church policies do not allow the Synod to promote SRH services.

OPSOMMING

Die studie is gemotiveer deur die verhoogde voorkoms van ongewenste swangerskappe, vroeë huwelike, onveilige aborsies en skoolverlatings onder die jeug weens 'n gebrek aan kennis oor seksuele reproduktiewe gesondheid. Die doel van die studie was om te verken en vas te stel of die CCAP swyg oor kwessies van SRH en, indien wel, hoe die Sinode die stilte kan verbreek.

Hierdie studie ondersoek hoe die CCAP Sinode van Livingstonia in Malawi teologiese konsepte kan betrek om die stilte te verbreek oor seksuele en reproduktiewe gesondheid. Die studie het gefokus op menswaardigheid as die hoof teologiese konsep wat verband hou met die beeld van God (imago dei). Die teologiese konsep van menswaardigheid het gefokus op sommige eienskappe van die beeld van God, soos onder andere onaantasbaarheid. Elke mens, geskape na die beeld van God, moet vry wees om hul regte kan uitoefen. Dit het verder ondersoek hoe die kerk SRH-dienste as deel van holistiese bediening moet beskou.

Die literatuur wat bestudeer is, het aangedui dat daar sommige SRH-determinante is soos sosiale en kulturele gedrag, sosiaal-godsdienstige oortuigings en swak gesondheidsfasiliteite. Die empiriese navorsing is uitgevoer binne die CCAP-opvanggebied, waar die deelnemers kerk-ouderlinge, kerkpredikante en jeug was, deur gebruik te maak van in-diepte semi-gestruktureerde onderhoude en fokusgroepbesprekings. Data is ontleed deur tematiese analise met behulp van teologiese interpretasies.

Die studiebevindinge toon dat die Sinode 'n SRH-beleid in plek het. Daardie beleid word egter nie geïmplementeer nie aangesien die SRH-beleid die kerk se geestelike leerstellings weerspreek wat onthouding onder die jeug beklemtoon. Bevindinge dui verder aan dat die kerk nie veel gedoen het om SRH onder die jeug te bevorder nie, want sou die Sinode betrokke wees by SRH-kwessies, sou dit gesien word as die bevordering van immoraliteit onder die jeug.

Byna alle respondente het egter aanvaar dat individue bewus is van die belangrikheid van en waardering het vir die SRH-pakket aangesien dit die jeug sal kan beskerm teen die gevolge van 'n gebrek aan SRH. Die bevindinge het verder bevestig dat die kerk kan getuig van skorsing van die jeug uit die kerk weens ongewenste swangerskappe ondanks voortdurende prediking van onthouding. Die ergste scenario was die dood van jong vroue in die kerk wat vermoedelik aan komplikasies van onveilige aborsies gesterf het. Kerklike beleid laat die Sinode egter nie toe om SRH-dienste te bevorder nie.

DEDICATION

I wish to dedicate this research project to the Lord our Creator for the provision of all that was required for me to finalize this project. Furthermore, I would like to acknowledge the support I got from my wife, and my children: Waliko, Wanangwa, Emmanuel, and Harold.

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GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
AYSH	Adolescents Youth Sexual Health

AYSRH	Addressing Youth Sexual Reproductive Health
CCAP	Church of Central Africa Presbyterian
CE	Church Elder
CM	Church Minister
CSE	Comprehensive Sexuality Education
GoM	Government of Malawi
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome.
IPCD	International Population Conference on Development
LISAP	Livingstonia Synod Aids Program
MHRC	Malawi Human Rights Commission
MDGs	Millennium Development Goals
MOH	Ministry of Health
SRH	Sexual and Reproductive Health
ST I	Sexual Transmission Infection
SDGs	Sustainable Development Goals
SRHR	Sexual Reproductive Health and Rights
UN	United Nations
WHO	World Health Organization
YFHS	Youth Friendly Health Service

CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

Sexual Reproductive Health (SRH) is a two-sided force that is both destructive as it is creative. On one hand, SRH can endanger society, and result in physical and psychological trauma when it is out of control. For example, the absence of proper information may result into destruction of the reproductive future of the youth because it has the potential to harm their ability to reproduce. On the other hand, if well-understood and promoted, it can be a force towards creating a healthy and productive society. Many SRH-related problems that are common among the youth include early marriages, teenage pregnancies, dropping out of school, and other factors as the literature review in subsequent paragraphs will discuss. SRH is a multifaceted issue that can be influenced by a variety of elements like culture, religion, the media, secularism, education, health, and infrastructure, among others. As such, addressing SRH challenges cannot be addressed by a single player or from one perspective. This multifaceted nature of SRH therefore requires an interdisciplinary approach to have a meaningful engagement with its challenges. A theological perspective should be now included in the interdisciplinary approach to sexual and reproductive health. Given this need for theological reflection, the goal of this study is to address the research question by examining how the church may view sexual and reproductive health as both a theological challenge, and a chance for youth ministry.

Generally, the church is perceived to be silent on matters of SRH. For instance, the church is afraid to freely speak on sexual matters to break the culture of silence, especially regarding reproductive health among the youths (Cloete 2012:4). Cloete (2012:4) further observes that sexual matters and questions are sometimes just so diverse and complex that the church's response is like shying away from addressing such complex issues. In other words, the church's silence could be a silent contribution to the problems of SRH among the youth. In many African societies, the silence of the church on SRH is also exacerbated by the fact that cultural discussions on sex and sexuality are taboo. To this end, Shemsanga (2013) in a study on the

Shambala in Tanzania coined the phrase: “the culture of silent sexuality”. In other words, Shemsanga confirms that silence on sex is common in Africa.

Contrarily, while the church is silent on SRH among the youth, the media, culture, and school curricula are not. This study seeks to intervene, and understand this silence by examining the extent to which the church is engaging or can engage with SHR issues, and possibly break church’s apparent silence on SRH as well as to promote SRH among the youths in Malawi. The focus of the study is on the CCAP Synod of Livingstonia. Synod of Livingstonia was chosen as a case study because the researcher is from the same church, and expects the church to be taking part in SRH among the youth.

MOTIVATION

As a researcher of this study, I was ordained as a minister in the CCAP Synod of Livingstonia more than 20 years ago, and I have been serving the Synod at some rural and urban churches. During my service, I had the privileged to head the church as Synod Moderator and Synod Youth director. All these positions and responsibilities for some years exposed me to numerous challenges that Christian youth are facing. However the church often don’t have no idea how to handle some of these social issues, especially sexuality of the youth. The predicament mentioned above motivated me to engage in this study, to ensure that the church have a better understanding what SRH entails and the churches role in adressing some of the challenges young people experience.

1.2. Basic Concepts

This section defines some basic concepts that are used in this study.

1.2.1 Youth and Youth Ministry

For this study, the term youth refer not only to teenagers, and young adults up to the age of 35 (as understood within the Synod of Livingstonia). Lewis (2009:12), and Root and Dean (2011:35) state that the aim ministry of the youth is to help and influence young people to identify God’s will for their own lives, their communities, and the environment. Nel (2000:103) also reaffirms that the objective of youth ministry is to assist young people in discovering their unique identity as given to them by God so that they can then persuade their peers to do the same. Given that youth ministry is not concerned with the youth ministers themselves, but rather God. It is a difficult responsibility to recognize, and lead young people into a personal

connection with God. As a result, the mission of youth ministry is made extremely difficult by the burden of discernment because it requires assisting young people to discover God's purpose for their lives by developing their pragmatic, and theological principles, which in turn will help them filter material acquired from the media (Beckwith, 1997:7).

1.2.2 Youth Ministry as Practical Theology

A significant body of literature makes references to youth ministry as practical theology. For instance, Dean and Root (2011:17) contend that youth ministry is a branch of pragmatic theology, which is the study of how God's acts interact with human customs, contexts, and circumstances. Nel (2003:67; 2005a:9) likewise argues that youth ministry is a sub-discipline and a practice inside practical theology, which supports the complementarity between youth ministry and practical theology. This suggests that the study of youth ministry mobilises practical theology. Noticeably, church ministers use a variety of strategies to address social concerns that concern young people both inside and outside the church. Similarly, these clergy members apply theology to real-world situations by helping young people with their social problems. McLaren and Campolo (2003: 113) suggest that Christians should employ youth ministry possibilities to ensure that social structures can tackle social challenges that society faces as a beacon of hope to the world. SRH is therefore one of the societal issues that has an impact on young people, and is the subject of this investigation.

1.2.3 Sexual Reproductive Health

SRH refers to two distinct but connected ideas that are both relevant to the subject of this study and young people in general. Additionally, SRH is a difficult idea that is frequently misunderstood or misinterpreted. As a result, this study confines its discussion of SRH to the World Health Organization's working definition of the two concepts, namely: reproductive health, which "addresses the sexual and reproductive processes, functions, and system at all times throughout life" (WHO, 2021: 12). Reproductive health implies that people can have a sexual life that is responsible, fulfilling, and safe as well as the ability to determine whether, when, and how frequently to procreate. The WHO defines "sexual health" as a state of sexuality-related physical, mental, and social well-being. It necessitates a positive and respectful attitude toward sexuality, and romantic relationships, in addition to the opportunity for joyful and risk-free sexual encounters devoid of compulsion, bias, and violence (WHO 2021: 14). Giving kids and teenagers the knowledge, abilities, and beliefs, they need to make

informed decisions about their SRH is the main objective of SRH. The CCAP views SRH as a holy thing, and a source of reproduction from a theological perspective.

According to the WHO, its SRH programmes and policies "relate to and include contraception and family planning, maternal and new-born health, prevention, and treatment of HIV and other STIs, promotion of sexual health, prevention, and management of gender-based violence, prevention of unsafe abortion and management of post-abortion care" (UNFPA 2017: 5).

1.3.Background of the Study

According to the World Health Organization (2012:16), an estimated 22 million unsafe aborti ons are performed each year. Almost 98% of these abortions take place in underdeveloped nations (Shah & Åhman, 2012:171). Each year, it is estimated that 25.1 million unsafe abortions occur worldwide, with 24.3 million (97%) occurring in underdeveloped nations (Faundes et al., 2020:103). In underdeveloped nations, the proportion of unsafe abortions was substantially greater than in industrialized countries (495% vs. 125%) (Faundes et al., 2020:103)

In addition, it is estimated that 7 million women are disabled because of the consequences of unsafe abortions (Fathalla, 2020:4). While such sinister incidents are happening, there remain affordable, effective therapies in most of hospitals and health centres to stop unplanned pregnancies, support pregnant, and labouring women safely, and prevent and treat sexually transmitted infections. Every year however, 80 million women experience unplanned pregnancies, 45 million of which result in abortion, and more than 120 million couples go without the contraception they need (Lutfiya et al., 2020:10). As discussing topics like sexual intercourse and sexuality makes people feel uneasy, SRH services are frequently either non-existent, insufficient, misused, or underutilised in many nations.

Meanwhile, the 2030 Agenda for Sustainable Development Goals (SDGs) was endorsed at the UN New York conference in 2015 by 193 member nations. The 17 comprehensive goals that were defined and adopted address a variety of areas that are crucial to sustainable development. These objectives included global goals for SRH, and rights for the first time (Liang, et al. 2019: 4). Target goal 5 of these 17 objectives specifically focuses on expanding access to sexual reproductive health, and rights (SRHR). Goal number 5 states: "Achieve gender equality and empower all women and girls." The World Health Organization (2021:23) also claims that

Goal 5.6 also intends to "ensure universal access to SRH and reproductive rights as agreed by the Program of Action International Conference on Population and Development, and the Beijing Platform for Action and outcomes documents of their review conference." To promote SRH, aim 5.6 calls on nations, various institutions, and organisations, including faith-based groups to fully participate in matters of Sexual Reproductive Health.

According to the Malawi Sexual Reproductive Health and Rights (SRHR) National Policy (2017: 64), the changing patterns of sexual behaviour, an ever-evolving social setting, and some detrimental customs of culture, present many difficulties for the country's youth. Likewise, the Malawi Demographic Housing Survey (MDHS 2015–2016), which was conducted by the National Statistics Office indicated that most young people begin to have sex as early as adolescence. Based on the report, 22% of women between the ages of 15 and 19 had previously given birth. The birth rate is quickly increasing, going from 5% among 17-year-old women to 59% among those who are 19. Furthermore, teenage pregnancy is more prevalent in rural areas than in urban areas for a variety of reasons, including poor access to health services and information, unequal gender norms, and a lack of understanding and knowledge of puberty, sexuality, and fundamental human rights related to sexuality (Malawi National Policy on SRHR 2017).

Although all Malawians are now guaranteed access to SRH care under the 2009 SRHR National Policy, these services are nevertheless difficult to access due to poor infrastructure, and the high cost of travel to these facilities. Furthermore, even in cases when SRHR services are offered, young people frequently find them to be neither convenient nor acceptable, let alone accessible (Munthali et al., 2004:24). Additionally, facilities typically offer services to both adults and teenagers in tandem. As they might not feel comfortable mingling with adults in such settings, adolescents are typically at a disadvantage (Munthali et al. 2004: 24; MDGS 2015-2016). Moreso, Limaye et al. (2012:117), assert that Malawi lacks access to effective sex education or provides insufficient information on SRH because of negative attitudes and perceptions towards discussing sexual matters to the youths, and other groups of people active in sexual matters. According to MDHS 2015–2016, the media, peer interaction, and personal interactions with community members are the main sources of SRH knowledge for many young people. Much of the information might not be correct or acceptable as a result. As mentioned above, sex education—or the lack of it—for school-age youths is not the only factor that contributes to lack of SRH information. SRH knowledge, SRH services, and access to these

necessities are equally important, and this is especially true for the age group that took part in the study.

Churches can help, even when the SRH information that reaches the nation's young people may not be suitable, sufficient, or readily available. The fact that young people make up three-quarters of those attending church services every Sunday and Saturday serves as the foundation for the church's powerful role in Malawi (Mthunzi, 2012:89). A poll performed by the Church of Central Africa Presbyterian Synod of Livingstonia (Synod Strategic Plan, 2008) indicated that the youth made up 60% of churchgoers who consistently attended Sunday services. Resultantly, the church has more opportunities to communicate with teenagers and provide accurate teachings and information regarding SRH.

1.4. Preliminary Literature Review

1.4.1. Christianity and SRH

The term Christianity was first used in Antioch because the followers of Jesus Christ had the behaviour, activity, and speech like that of Christ (Mulenga, 2013:202). Mulenga (2013:202) further observes that it is for that reason that Christianity is defined as the "way" of moral life that exemplifies how Jesus lived. It is imparted when one believes in Christ Himself. Christianity teaches its believers to maintain the holiness that Christ taught his followers. Some of the teachings about sexual life that promote abstinence or no sexual intercourse outside marriage and adultery refer to 1Thessalonians 4:3-5. This Christian sentiment, however, runs the risk of supporting harmful ideologies that are endangering the youth's well-being and overall health. It is difficult to assume that every young Christian who has been encouraged to follow this teaching of abstinence will adhere to it. The Christian faith is in a dilemma on the teaching about faithfulness and abstinence, and how to deal with the realities of sexual experiences. This dilemma is evident in the increased rate of teenage pregnancies.

Concerns have also been raised about the Church's silence on matters of youth sexuality, and failure to seriously take the reproductive health of the young people in its congregations. This has led to many youthful adults in the Church engaging in dangerous sexual behaviour, and becoming sexually active (Tazhmoyeet, 2011:165). Sadly, Cloete (2012:4) affirms that this quietly allows others, like the media, to take the initiative in the conversation about sexual matters. Since intimate nuances of private experiences are shaped by larger social ties, it is

regrettable that many individuals do not realise that sexuality is both a public and a private matter (Spronk, 2009:505).

Considering this context, the goal of this study is to determine how the CCAP church Livingstonia synod may speak up and contribute to the advancement of SRH issues. Christians are interested in development work, Christianity emphasises living a life of empathy and service to other people, particularly the weak (DeGruchy, 2003:20). The author further opines that this encapsulates the Biblical testimony of Moses and the Jubilee Laws, as well as of Jesus Christ and the message of the Kingdom of God (De Gruchy, 2003:20).

1.4.2. SRH and Media

When it comes to SRH, many individuals are influenced by the media, especially young people (Mcharo et al., 2021:5). Many churchgoers also consume images and messages from popular media forms such as radios, television, periodicals, and social media. Since the media is the only world children are familiar with, it is an integral component of their daily life (Cloete, 2012:3). For instance, children residing in urban areas easily get an access to the media, particularly television, from a very young age. According to Borgan (1994, p. 15), "television has become the nanny or babysitter of modern children, in many homes, both rich and poor, busy mothers tending babies and family need to allow children to watch televisions throughout much of the day and night.”. Cloete (2012) states likewise that "the older children become, the greater the access and the wider the variety of media [they] are exposed to." Similarly, Hoover (2006:142) argues that, despite best attempts, it is impossible to avoid the media entirely due to its pervasiveness, and variety of formats (multimedia).

Noticeably, the media might not convey the right message to various age groups or provide the answers these young people may be looking for. Despite having laws governing the media, governments may not be able to control additional sources such as mobile devices and other social networking platforms. Brown (2002:42) affirms that little is known about how the information is used and how it influences young people's sexual views and behaviours. Girls may for instance experience influence from social media in numerous settings over how they should act and look, thus sustaining double standards of sexuality that support gender stereotypes (Brown, 2002:43). In this sense, it is believed that the media has a significant impact on young people's sexual behaviour.

1.4.5. SRH and Culture

Culture plays a big role in human beings' lives. It influences people's lifestyle and can contribute both positively and negatively towards developmental issues. The patriarchal cultural framework in which the CCAP Synod of Livingstonia operates involves various cultures becuase the Synod operates in several locations with diverse cultural practices. These cultural norms and practices lay foundations for shaping a particular society. As CCAP Synod of Livingstonia operates almost in all the regions in Malawi, a need for inclusion of variety of various cultural practices that shape most societies had also become pertinent. Since this study concentrates on northern region of Malawi, it is imperative to include cultures that shape northern societies where the church operates.

There are several cultural practices in northern region of Malawi that shape various societies in Malawi. Integral to this study are cultural practices related to marriage, sexuality, and sex education. In relation to marriage are cultural practices such as polygamy, wife inheritance (levirate, chokolo, kuhara), replacement of a deceased wife (chimeta masisi), bonus wife (hlazi, kupimbira, kupawila), marriage by proxy, child preference and practices related to the birth of a child, resumption of sexual intercourse after the birth of a child, among others. Despite the wide variety of cultures, people have certain characteristics of how they view sexuality. For instance, parents are not permitted to talk about sexual topics with children or anyone who is not their own age. In agreement, Musopole (2006:15) notes that Malawian traditions have a dubious view of sexual activity. The author explicates how Malawian traditions keep sexual life hidden. Most of the parents also view discussing sex with children as humiliating, and sinful.

Furthermore, there are observed similarities in most countries in Africa about the role of culture in contributing to silence onSRH matters. For example, in Tanzania, the Shambala tribe is one group that practises the culture of silence (Shemsanga, 2013:1). Shemsanga notes that as children are born in secret, sex is also not a public activity and is only performed reverently and in secret within marriages. In a similar vein, Alexander (1993:288) emphasises that "parents and children cannot talk with each other about sexual information, issues, and values". In parents' views, discussing sex with youngsters promotes sexual behaviour. Due to this silence, young people may in turn be exposed to a variety of scientifically erroneous, contradictory, and perplexing information concerning SRH, which can later pose major threats to their health, happiness, and dignity. Considering the silence surrounding sexual education in

Malawi, this study investigates if such a silence culture persists, and whether it has an impact on the SRH life of young people in the Livingstonia synodal area of the CCAP.

Observably, some African communities even conduct initiation rites despite that most African societies frown upon parents who discuss SRH with their biological offspring. Most African societies see these initiation rituals as being crucial to daily life. According to Mbiti (1990:119), initiation procedures signal the start of learning things that are otherwise unavailable to individuals who are not initiated. He further states that without being initiated, a person is disliked and regarded as still being a small boy or girl, regardless of how old they are. It is also believed that a person's life is marked by initiations as they go from one stage to another. Fiedler (2005:7) defines initiation rites as transitional rites that take a person from a lower level in the society to a higher level. She further explains that between these two levels is the "camp", the liminal phase in which the initiates are secluded from the society to be initiated into the mysteries of life (Fiedler, 2005:7).

In this context of initiation and ritualisation girls get puberty lessons known as Kulanga Mwali, one of the frequent initiation rites among the tribes of northern Malawi. These girls are expected to receive instruction on how to observe signs of sexual body development in their bodies, and their sexuality at this initiation rite. In Tonga, Tumbuka, and Ngoni cultures, a girl is supposed to tell her aunt and not her mother when menarche occurs. If the aunt lives far away, or she is not available when the girl experiences her first menstrual period, she is supposed to tell any other close relative. Mwase (2012:19) believes that the aunt is responsible for informing the initiate's parents that their daughter has had her first period, which in Tumbuka language is known as *Wakatsuki*. The above indicates that teenage girls often got sex education from a female family member, usually an adult (such as an aunt or grandmother). This instructor would from time to time instruct the teenage girls in issues of female hygiene, and solely abstinence regarding sex issues (Longwe, 2003:1). The only official manual on SRH provided to adolescent girls is the scant information delivered during this initiation. Although the girls get these instructions on various subjects on sexuality, there still exists external influence both from their peers and media.

Additionally, the church discipline reports also include information about teenage pregnancies, and early marriages. There is a need therefore for a comprehensive knowledge on needs of the youth about SRH. The involvement in programmes that empower young people on spiritual,

socioeconomic, and health-related issues as the Synod Youth Director is therefore very important. I have realised that many young people are at the risk of choosing their SRH poorly or dangerously due to a lack of proper information regarding SRH.

1.5. Focus of the Study

This study focuses on whether there is a culture of silence around SRH in the synod area of the CCAP, Livingstonia, and if yes, how? The focus also involves concerns about whether the church is contributing to this silence, or intervening to address it. The study also assesses whether what is being done now is sufficient, or could be done better. In this case, the study investigates whether overcoming the taboo surrounding SRH concerns gives the CCAP Livingstonia Synod the opportunity to further its work among the church's youth. Meanwhile, Livingstonia Synod's agenda includes SRH-related problems. In 2016, the Synod Health Department created the Sexual Reproductive Health and Rights (SRHR) policy. As discussed later, the policy does not approach this question as a theological conundrum, but rather as a matter of right. The Synod Health Department's Sexual Reproductive Health and Rights (SRHR) policy of 2016, and the general practices of the Church regarding SRH are also discussed in this study.

The church's SRHR policy has some issues as evidenced by certain instances. The demand for, and accessibility to (SRH) services by communities inside and outside the Synod of Livingstonia's administrative jurisdiction is supported, for instance, by policy guideline paragraph 3.0. Contrary to what is stated in the government's policy, the CCAP SRHR explicitly states (concerning family planning) in paragraph 2.2 that the church does not accept the use of condoms as one of the contraceptive methods for unmarried youth (SRHR Policy, 2016:8). This is where the CCAP SRHR differs from the Malawi Government's policy. It is also an instance where the church's teaching on celibacy before marriage is put into practice. This implies that such teaching restricts youngsters' access to SHR resources, and ignores their SRH needs. This stance taken by the church regarding youth access to SRH services suggests an absence of a place for discussing SRH among its members, and that the church does not accept responsibility of helping the young members in relation to their SRH.

Another issue is the lack of any explicit instructions on how the church or congregations should support SRH in a theologically sound manner as youth ministry. Therefore, the purpose of this study is to determine whether the policy is sufficient, and how much it is encouraging SRH from a theological standpoint. Since this is the first study of its kind in the Synod of

Livingstonia, the study further offers to investigate how the church, with its unique principles, might break the silence, and practically respond to the realities of adolescents' and young people's needs regarding SRH. The study further addresses how the church and the government might work together to promote contextual issues relating to SRH. Additionally, the church has a responsibility to work with the government, but also, as necessary, to prophetically challenge society at large.

1.6. Practical Theological Framework

Practical Theology engages several different methodologies with a wide range of methodological approaches that can be used in a single study. One of the common methods of Practical Theology is the hermeneutical approach (Louw, 1998:97). The Hermeneutical process involves "the interpretation of the meaning of interaction between God and humanity engaged in the praxis through faith community in order to transform the world" (Louw 1998:97). In the same vein, Swinton and Mowat (2006: 76) add that aim of hermeneutical/interpretive paradigm is to focus on the interpretation of different dimensions such as situations, Christian practices, scripture, and tradition, to draw various hermeneutic perspectives in the effort to understand God and human experiences. There are four phases that must be considered when applying hermeneutical research methods: the phase of description or observation, the phase of critical analysis, the phase of critical reflection and systematizing, and the phase of design (Louw, 1998:98). Briefly, the first phase (description or observation) aims to identify the problem and expose the realities. The second phase (critical analysis) is a critical stage of data analysis. The third phase (critical reflection and systematizing) seeks the theological meaning and impact of data. The fourth and last phase (design) seeks to develop a strategic plan for the purpose of influencing and transforming the problem in question.

There are many different practical theological frameworks, however, this research uses Richard Osmer's practical theological perspective because this method is interdisciplinary. August (2010:93) observes that multidisciplinary approach engages with other disciplines such as economics, sociology, and political science. Hancox (2020: 16) also adds that practical theology accommodates an interdisciplinary approach, and empirical studies. This means that the approach is capable of theologising SRH from a theological interpretation of the violation of human dignity, and sexual rights.

Furthermore, Osmer (2008:3) claims that ministerial experiences act as instructive moments that help people learn critical abilities and information. These encounters carry with them ministerial difficulties that are not confined to one strategy or discipline. This study is interdisciplinary since SRH is a topic that generally affects society (including culture, government, gender, religion, media, and education). For this study, Osmer's framework is the best framework to employ as it is well applicable in studies with practical theory background. To determine what a practical theological meaning for an event or experience is, Osmer (2008: 4) suggests completing three theological chores, namely the normative task, the interpretive task, and the descriptive-empirical task.

By asking "what is going on" in the area where the investigation is taking place, the descriptive-empirical task is concerned with acquiring the data required for the success of the research study. This study aims to investigate the SRH promotion efforts made by the (CCAP) Synod of Livingstonia regarding this duty. The Synod is required to work with the international community to promote SRH, which remains a worldwide issue. Due to improper SRH communication, young people's economic progress is being hampered by early marriages and teenage pregnancies. Other disciplines have influenced the SRH of the youth in addition to improper communication.

By comprehending the pertinent theories at play in various contexts, the interpretive task seeks to "explain why" patterns and dynamics have developed within the context. Contextual analysis is crucial for this endeavour since it examines the numerous systems operating inside each congregation (Osmer, 2008:17). While analysing other aspects that might be connected to this reason, this activity will assist this study in understanding why SRH concerns are problematic. SRH is an intersectional study. It is a topic that touches on many different topics, as stated in the introduction. The biological, social, cultural, and theological facets of human life must all be considered.

By creating moral standards and examples of ethical behaviour that are suitable for the difficulties congregations encounter, the normative job aims to analyse how the patterns have emerged. This job will assist this research in addressing the topic of how the Church should support SRH within a theological framework through its youth ministry. Osmer (2008:28) asserts that the interpretation of practical theology makes it easier for the congregation to participate in Jesus Christ's tripartite ministry of Priest, King, and Prophet. Jesus' three-fold

ministry prioritised meeting people's bodily and spiritual needs. As a result, this study applied a practical theological framework to youth ministry.

The pragmatic task is intended to address how congregations can move forward following discussions of the three tasks. This focuses on creating models and guidelines for action that are used to direct occurrences toward any desired congregational goals. This assignment in this study thus provides direction on how to create youth ministry plans for SRH promotion. To comprehend what is happening regarding SRH concerns therefore, Osmer's three practical theological responsibilities were used. Why is it difficult? What should be the theological practical reaction to what is occurring? And does the CCAP Synod of Livingstonia handle SRH as a problem or as an opportunity for youth?

1.7. Research Problem, Research Questions, and Objectives of the Study

Several variables, including culture, education, religion, and the media landscape have an impact on SRH, making it a complicated topic. Teenage pregnancies, early marriage, and the high rate of school dropout that goes along with them are a few of the SRH issues that the youth must deal with. A few societal role actors, including the church, must therefore advocate for SRH to address these issues, which have also been noted in some church documents. Currently, it appears that this is not the case, and one reason for this is church being mute on SRH matters, particularly in relation to young people. Unfortunately, the church lacks a real, actionable policy on SRH, and it is especially silent when SRH related issues are on the rise. The *aim of this study* is therefore to investigate and establish whether the CCAP is silent on issues of the SRH of its youth members by answering the following **research question.**

How can the CCAP Synod of Livingstonia break the silence on SRH services in a theologically responsible way through its youth ministry?

This research question will be answered by addressing the following **objectives**.

1. To describe the concepts and the importance of SRH as they pertain to the youth.
2. To examine the social, cultural, and religious factors that may influence the perceptions of SRH in Africa in general and in Malawi specifically.
3. To determine the presence or absence of silence on the SRH of the youth in the Synod of the CCAP Synod of Livingstonia.

4. To discuss the theological grounds for speaking out on the SRH of the youth in and by the Synod of Livingstonia.
5. To suggest practical ways in which the Synod of Livingstonia, via its youth ministry, can break the silence on the SRH of the youth.

1.8. Research Design and Methods

This study employed a qualitative empirical approach. Mouton (2001: 55) argues that "a research design is a plan or blueprint of how you intend to conduct the research". Encouragement of participant expression and comprehension are the cornerstones of qualitative research (Walliman, 2006:3). A qualitative method, according to Hendricks (2004:226), involves analysing and interpreting observations to identify the underlying themes and correlations. This research method gathers data from participants on their observations, behaviours, feelings, and opinions (Onwuegbuzie & Leech, 2006:482; Mouton, 2011: 150). The CCAP Synod of Livingstonia was selected as the case study for this project. A case study's advantage, is that it captures the reality of issues. In addition, a case study is typically undertaken inside a specific context rather than generalised to some theoretical population by presenting comprehensive details as well as insights into the real-world circumstances of a specific group of respondents (Babbie & Mouton, 2010:105, Yin, 2009:2; Mouton, 2011:150).

1.9. Data Collection, Sampling and Recruitment of Participants

Three categories of participants were recruited. These included ministers, church elders, and youth members of the church. Although “the youth” included minors, but participation was limited to persons between the ages of 18 and 35. The participants included males and females. A request for involvement was sent to the congregations in two presbyteries of the Synod of Livingstonia. The presbyteries were in the rural Euthini, and urban Mzuzu areas. Picardi and Masick (2014:154), Salkind (2012: 72), and Mason (2010:7) believe that qualitative samples should be large enough to ensure that the majority of the ideas, perceptions, and experiences that may be significant to the topic of discussion are uncovered while also avoiding too many samples that can result in using superfluous words and ideas. A total of 30 participants were enrolled in the study, (i.e., five ministers, five elders, and six youths) were chosen from each of the presbyteries. The researcher sought some ministers who were familiar to him, these ministers also suggested other potential older participants that the researcher sought out. Some adolescent participants were recruited through posting of fliers on the notice boards to invite them to join the discussions.

Focus group discussions (FGDs) and individual semi-structured interviews were both employed as data gathering techniques. Individual interviews are unquestionably the most popular method of measurement for gathering data for qualitative research (Pattern & Newhart, 2018:161). Interviews were used because they enable the researcher to elicit more in-depth responses when the respondent is prompted to elaborate on what they have stated (Gary, 2009:370). The qualitative interviews place a strong emphasis on the interviewee's voice, the cultural relativism of the process, and the interviewer's active participation. It is envisaged that cultural interviews will be used to explore the norms, values, perceptions, and accepted codes of conduct related to SRH. The researcher believes that "face-to-face interviews method has low bias," while Gary further (2009) states that face-to-face interviews enable researchers to see elements like tone, gestures, and facial expression that contribute to the interpretation of what is said. Moreover, the use of semi-structured questions enables respondents to describe their ideas and experiences in their own words (Picardi & Masick, 2014:150; Hansen, 2013:51).

Data from the participating young people was collected through focus group. FGDs are a type of qualitative data collection where a heterogeneous or homogeneous group of three to fifteen people meets and converses informally about a chosen subject to gather a variety of qualitative data (Fouche et al., 2021: 361). FGDs were chosen over one-on-one interviews because participants could feel more at ease sharing their perspectives in a group setting. Participants can also disagree with one another's viewpoints while gathering a variety of data (Fouche et al., 2021:363). The interviewer's job is to keep the conversation on track while taking notes to add to the tape and transcription.

Two research assistants were recruited to assist in conducting FGDs. Students in the researcher's network at the close-by University of Livingstonia were used to find the assistants. This was done because talking about SRH-related topics with peers was more comfortable for the participants than doing so in front of a minister. Furthermore, focus group ethics were covered in training, and the participants in the study signed non-disclosure agreements. All the participants were reminded of the importance of maintaining confidentiality during the FGDs.

Before the actual data collection began, pilot study with two elders (one male, and one female) and three congregational adolescents was done at the Katawa Congregation. Through this pilot study, the researcher was able to assess the questions' clarity, readability, and ability to address the research issue.

Finally, the data was thematically analysed. The purpose of thematic data analysis is to identify recurrent or irregular themes and concepts in the data that would lead to a more comprehensive explanation. Materials from focus groups and interviews were gathered, evaluated for subtle differences in meanings, and then compared across categories to find linkages between themes. The final objective was to combine the themes and ideas into a theory that provides an exact, in-depth, yet nuanced explanation of the research subject.

1.10. Ethical Considerations

Since doing scientific research involves human behaviour, it follows that this behaviour must adhere to acknowledged standards and principles (Mouton, 2001:238). The study was approved by the Stellenbosch University Research Ethics Committee. Interviews with church leaders and members were conducted with the Synod's and Presbyteries' approval. Care was taken to ensure any Covid-19 protocols required in the area were followed. Furthermore, no minors were interviewed, but only adults and youth between the ages of 18-35 (as per the definition of youths by Synod of Livingstonia). The need for confidentiality was emphasised notably during FGDs. All information submitted by the participants was also treated as confidential. Similarly, all paper field notes were retained in locked files, and all recorded material was downloaded onto a password-protected computer, and on a secure online platform, Microsoft OneDrive. The use of pseudonyms, and the absence of any personal identification information guaranteed all participants' anonymity. All the participants got a briefing about the study's goals, and were required to sign informed consent forms before being allowed to participate.

1.11. Relevance of the Study

This is the first study to be conducted on SRH in the CCAP Synod of Livingstonia, therefore its findings are capable of providing theological guidance for church ministers, church counsellors, and the entire church concerning SRH in its youth ministry. In a broader sense, the study may complement the Malawi Government's efforts to improve knowledge of challenges related to SRH among the Malawian youth, and showing more ways to address such challenges to attain the 2030 Sustainable Development Goals (SDGs).

1.12. Chapter Outline

Chapter 1: Introduction- Chapter one introduces the research understudy and explains the background of the study. It discusses key concepts within this study and gives the aim of the study, and the research question of the study.

Chapter 2: SRH concepts and public policies- This chapter explores the definition of SRH policies. It investigates different ideas of SRH as well as the causes and consequences of its absence. Additionally, it analyses sexual health policies and their efficacy or lack thereof. The goal of the discussion is to pinpoint gaps in order to determine how this research can achieve its goals.

Chapter 3: SRH in socio-cultural beliefs: This chapter discusses a general background of how some cultural practices influence the sexual reproductive health of the young people. The debate strikes a balance between how culture might influence young people's SRH in both positive and bad ways. This conversation also closely examines how cultural attitudes about sexual and reproductive health may have influenced Christian beliefs.

Chapter 4: SRH and Religious beliefs- This chapter analyses how religious beliefs affect the SRH of young people. It further discusses how religions in general may have contributed positively or negatively towards the sexual life of young people.

Chapter 5: SRH: A Theological Perspective- This chapter focuses on how this study can use theological concepts of human dignity to answer the research question of this study and to consider SRH as a theological challenge.

Chapter 6: Research Methodology- This chapter presents a detailed discussion on how this qualitative research study collected and analysed data. The data was collected in the catchment area of CCAP Synod of Livingstonia, within two presbyteries, i.e., one in the rural area of Euthini, and one in the urban area of Mzuzu.

Chapter 7: Findings and discussion- This chapter comprises the data analysis and discussion mainly with a focus on the theological concept of human dignity. The main aim was to see how the church can establish a theological approach on how to implement sexual reproductive health among the youth as youth ministry.

Chapter 8: Recommendation and conclusion- This chapter gives a summary of the findings and recommendations of this study to Synod of Livingstonia, and the church in general.

1.13. Conclusion

This chapter introduced the study. The main purpose of this study was to investigate how the church can break the silence on SRH on theological grounds, and provide tools to the synod. It started by giving the general background on the state of SRH of the youth, and laid a background for the discussion of this study. The chapter also showed the rising rate of teenage pregnancies and the policy of the church on SRH. The chapter also discussed key concepts and the methodology that guided this research to address the research question of this study. The chapter was broken down into the motivation of the study, the statement of the problem, the research question, the aims of the study and, finally, it provided the outline of chapters of this study. The next chapter discusses conceptualisation of SRH.

CHAPTER 2

CONCEPTUALISATION OF SEXUAL REPRODUCTIVE HEALTH

2.1 Introduction

This chapter gives a general overview of SRH as it is conceptualised by the international organisation such as World Health Organizations, Pan American Health Organization, and Africa Health Organization among others. Additionally, it provides a thorough analysis of several aspects of sexual and reproductive health. The field of SRH crosses several disciplines. In line with Osmer (2008:4), this chapter uses interpretative tasks to comprehend various ideas of sexual and reproductive health by concentrating on an interdisciplinary understanding of concepts with a focus on various role players in SRH. The chapter scrutinises some factors that affect or hinder sexual and reproductive health. The main emphasis is on how these determinants affect young people's SRH. This chapter examines the effects of youths' lack of sexual and reproductive health, and how such lack may affect their lives after examining and discussing these determinants. The direction provided by this introduction helps this study better respond to its research issue from a theological standpoint.

2.2 Defining SRH Services

SRH is described as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system, and to its functions and processes" (WHO 2017:1). This definition of SRH was proposed at the International Conference on Population and Development (ICPD) in Cairo in 1994 (WHO, 2017:1). SRH encompasses a wide range of health-related topics such as family planning, maternity, and newborn care, STI prevention, detection, and treatment, including HIV adolescent SRH cervical cancer screening infertility prevention and management, and sexually transmitted infections (STI) prevention and treatment. These services are designed to prevent poor SRH, including problems during pregnancy and childbirth, unwanted pregnancies, unsafe abortions, complications brought on by STIs, sexual assault, and women dying from preventable cancer (WHO, 2017:1). It is crucial to remember that the idea of sexual and reproductive health has developed to provide a thorough and integrated approach to health issues connected to sexuality and reproduction. According to Edwards et al. (2004:189), the way the word "SRH" has been understood has changed in intriguing ways over time. This understanding is influenced in part by political, social, and historical occurrences like the

sexual revolution, the ongoing debate over abortion rights, the development of the gay rights movement, concerns about overpopulation, and the devastating effects of HIV/AIDS on the global community (Edwards et al., 2004:189).

Furthermore, achieving SDGs depends on sexual and reproductive health (Metusela et al., 2017:836), and this remains a matter of public health, human rights, and SDG achievement. Metusela et al. (2017:836) maintain further that, SRH is a crucial aspect of achieving equality in life. This includes having joyful sexual encounters free from coercion, discrimination, and violence, as well as having one's physical, emotional, mental, and social needs met. Included in this are also the rights to equality and the absence of discrimination, the right to decide the number and spacing of one's children, and the freedom to experience and express sexual desire. Reproductive health therefore entails that individuals may engage in pleasant and secure sexual relations, can reproduce, and have the choice of method of contraception.

Definitions of sexual health have changed because of the public health issues that called for numerous technical discussions and publications. Sexual health does not only refer to the prevention of unintended pregnancies and diseases, but more importantly it encompasses the skills necessary to: a) build and maintain meaningful relationships; b) interact with people of both sexes in a respectful and appropriate manner; and c) express affection, love, and intimacy in ways that are consistent with one's values (Tsui et al., 2007:22). This definition was adopted at the United Nations International Conference on Population and Development (ICPD), which took place in Cairo in 1994. The ICPD set the objective that countries should work to make reproductive health accessible, through primary health care systems, to all people of appropriate ages as soon as possible, and no later than the year 2015(UN, 1989: 13).

In addition, the right to access appropriate healthcare services that will enable women to experience pregnancy and childbirth safely, and give couples the best chance of having a healthy infant is implicit in this condition. This is because these are parts of the rights of men and women to information and access to family planning methods of their choice that are safe, effective, affordable, and acceptable. Importantly, integrating psychological, physical, sociological, cultural, educational, economic, and spiritual components is necessary to achieve sexual wellness. The term "sex", then, is not limited to the absence of illness or malfunction, nor is its significance restricted to the reproductive years only. It also includes the capacity to exercise abstinence when necessary, and to comprehend and balance the dangers, obligations,

results, and repercussions of sexual actions. The capacity for people to integrate their sexuality into their life, enjoy it, and procreate, if they so want, are all included. The same is applicable to freedom from sexual abuse, and prejudice.

2.3 Dimensions of SRH

2.3.1. Human Rights

This section is going to investigate how sexual reproductive health is linked to human rights and how it affects or influences the SRH of the youth. This examines the necessity of considering the appropriate issues when talking about SRH general. This conversation helps to further direct this research's consideration of how it might relate to concerns about sexual rights, religious convictions, and the role of the church in SRH.

Moreover, reproductive rights include several rights that are already protected by international human rights treaties, state laws, and other consensual instruments. These rights are based on the understanding that every couple and person have the fundamental right to choose for themselves the number, spacing, and timing of their children and to have access to information and the means to do so as well as the right to make decisions about reproduction without fear of coercion or violence (UN, 1989:40). Relatedly, SRH and rights are essential to the social and economic development of people, couples, and families as well as to the development of communities, and countries (WHO, 2014: 10).

Comparably, those rights were stated explicitly in the declaration and platform for action adopted by 187 UN Member States at the World Conference of Women. According to UN, (1989:39). "The human rights of women include their right to have control over and make free and responsible decisions regarding matters associated with their sexuality, including SRH, free from coercion, discrimination, and violence". Equal treatment of men and women in sexual and reproductive concerns, including complete regard for each person's integrity calls for mutual respect, consent, and shared responsibility for sexual activity and its effects (UN, 1989:39).

Meanwhile, SRH and rights include initiatives to reduce avoidable maternal and neonatal mortality and morbidity; to guarantee high-quality SRH services, including contraceptive services to address STIs and cervical cancer; violence against women and girls; and to meet the SRH needs of adolescents. In order to realise sustainable development and ensure that this new framework relates to the needs and aspirations of people around the world, and leads to

the fulfilment of their health and human rights, universal access to SRH is necessary (World Bank Report, 2014: 9).

Furthermore, improved fertility management enables girls to complete their education, acquire more knowledge, and eventually earn more money. The World Bank reports that female labour force participation declines with every additional child by roughly 10-15 % among women aged 25 to 39, and by roughly 5 to 10 % among women aged 40 to 49. Ensuring that everyone has access to SRH is therefore not only a crucial human rights objective to ensure gender equality and women's empowerment, but it is also a crucial international development priority. Since the declaration of universal access to SRH care, some member states appear to have done very little. Most African nations, including Malawi, continue to face difficulties because of deficient healthcare systems and other related social and cultural issues, as detailed in the following paragraphs (WHO, 2021:14).

Although everyone in 187 UN Member States at the 1995 Fourth World Conference of Women declaration was given the right to seek medical treatment in 1994, Temmerman (2014: 16) comments that young people under the age of 25 are particularly susceptible in the setting of SRH. Adolescence is a time of sexual and reproductive maturity, yet in many nations, teenagers lack access to crucial and timely resources about SRH, necessitating their urgent need for them. According to estimates in Government of Malawi (2022:16), 16% of new HIV infections happen among people under the age of 15, while 42% happen among those aged between 15 to 24 in Malawi. This is a blatant sign that most teenagers around the world have a high risk of contracting STIs. Some infections may not have been reported in the statistics above, according to some experts. If we wish to attain the SDGs through SRH, this should be a concern for several groups, including the church community.

In addition to their right to access information and materials from a variety of national and international sources, particularly those aimed at promoting their social, spiritual, moral well-being as well as physical and mental health; adolescents are also given significant protection under the Convention on the Rights of the Child. The right includes having privacy and confidentiality about their medical information, and protection from all forms of abuse, neglect, and exploitation. How much is being done to ensure that the child protection right is implemented is the next logical issue. What obstacles must member countries overcome in

order to enforce this law and guarantee that all children can easily access these services? Is it possible to accomplish sustainable goals through sexual reproductive health?

It is important to note that obstacles to SRH exist on a number of levels, including legal, social, political, financial, attitudinal, and cultural ones. These barriers also interact in a complex manner. What rights add to this mix is a framework for programming and action as well as a legal justification for government responsibility. The framework not only provides pertinent services, but also changes the circumstances that exacerbate, and perpetuate poverty, deprivation, marginalisation, and discrimination. All these circumstances have an impact on reproductive and sexual health (Temmerman, 2014:11). The ability and responsibility of governments to translate their global obligations into national and sub-national programmes that promote reproductive and sexual health must therefore be brought to light (Temmerman, 2014:16).

2.2.2 Religion

Religion, which is a phenomenon that transcends cultures is one of the causes that affects and influences SRH. The impact of religion on young people's sexual and reproductive health is discussed in this section. This section continues to explicate variables that may have both positive and bad effects on young people's sexual lives. Regarding how the church might view SRH as a theological challenge and potential for youth ministry, the criteria identified in this discussion serve as a framework for this research.

As religion and morality are important tenets of many African communities, sexual issues are frequently seen from the perspective of morality in many African situations. As a result, religion becomes the central theme in all conversations about sexual behaviour (Anarfi, et al., 2010:5).

There are many ways to characterise religiosity. The self-appraisal level of religiosity and participation in religious services are two typical proxy variables used in this study to measure religiosity. The tendency of viewing religious channels on television, reading the Bible, or other religious books, and saying prayers or grace before meals are all examples of private religious behaviours that are supported by religiosity (Underwood & Teresi, 2002:23). The formal, institutional, and public representation of the holy is called religiosity, and it can be gauged by factors including how important a person feels about religion, whether they believe

in God, how frequently they attend religious services, how often they pray, and how often they meditate. In terms of sexual influence, religiosity enables teenagers to make life decisions based on religious beliefs, and teachings (e.g., refraining from premarital sexual engagement owing to religious teachings).

Several studies have found that religiosity has an impact on young people's sexual health. For example, Rostocky et al. (2003: 359) studied the Role of Religiosity and Sex Attitudes in the Add Health Survey. In-home interviews from the National Longitudinal Survey of Adolescent Health (Add Health) were tested. The study found that religiosity increases the delay in vaginal sexual intercourse among young white females during adolescence. Furthermore, Beckwith and Morrow (2005: 360) studied attitudes and perceptions of college students on the impact of religiosity on sexuality. The researcher had also observed that those who are deeply religious have more conservative sexual views and sexual permissiveness beliefs than their peers, which may lead to fewer sexual experiences. Similarly, findings from a study on religiosity among college freshmen revealed that individuals with low levels of religiosity were more likely to be sexually active (e.g., had engaged in sexual intercourse activity within the previous year) than those with higher levels of religiosity.

With this understanding of religion's role in society in mind, many Christian denominations have emphasised the doctrine of abstinence or no sex before marriage. This is a method of preserving adolescent purity and virginity. Some churches have gone so far as to penalise those who have been caught having premarital affairs. Several churches do suspend youth who have been discovered to be pregnant out of wedlock, even though these youngsters are religious in practice. The Presbyterian Church in Malawi, for example, prohibits such people from attending church services. This is a prevalent practice towards girls who become pregnant without being married. The irony here is that this practice is based on the Hebrew Bible’s condemnation of adultery, according to the sixth commandment that refers to those who are committed to marriage.

Apart from preaching abstinence, or no sex before marriage as a component of religious beliefs, people of high religious conviction do not address sexual concerns with their children. The study of Farringdon et al. (2014:102) sought to determine whether there was a link between maternal sexual health awareness, religion, and comfort addressing sexual health topics with teenagers. Farringdon et al. (2014:102) discovered that mothers with an elevated degree of

religiosity reported feeling uncomfortable discussing specific sexual health issues (abortion, condoms, masturbation, and sexual assault), leaving adolescents to judge for themselves what is safe and religiously acceptable sexual conduct. If these women choose not to discuss these issues with their children because it is in contradiction with their religious views, they may create a knowledge gap on SRH to their children—a thing which might be very detrimental -- to the sexual lives of their children. This religious practice contradicts sexual rights, which mandate that all young people and adolescents get correct and comprehensive sexual health education. Teaching and believing in abstinence as well as being uncomfortable discussing sexual problems with their children may therefore put children at risk of sexual damage. The difficulty with this concept is that various people have varied levels of religious attendance and beliefs, sometimes known as religiosity. A study that looked at the strength of convictions in religion and health risk factors nonetheless discovered that strong religious belief (high religiosity) was a protective factor against risky behaviours including sexual initiation (Farringdon, 2014:96). While religion encourages abstinence from sex, youth culture acquired through media is a potential source of sending and receiving varied sexual information among the youth these days. The following section goes into greater detail about youth, sex, and the media. It is against this sparsity in silence among most of the parents that this study seeks to investigate how the church may break the silence on sexual reproductive health.

2.2.3 Education

This section concentrates on how sexuality education impacts, and shapes young people's sexual reproductive health. It also identifyies essential key topics as well as any gaps in the area of church’s silence on SRH. Sex education is taught in schools, and it covers all aspects of SRH in Malawi. At times, knowledge taught in schools is delivered to students of the wrong age. Specifically, education is a deliberate, systematic process for imparting knowledge and skills and influencing an individual's growth path. Literacy entails more than memorising facts and recognizing symbols; but also, the abilities required to combine knowledge in an important manner, allowing one to articulate ideas, make decisions, and solve problems (Ronny, 2007:116). Sex education is an important component of a diverse approach to addressing teenagers' high need for SRH information, and services. Meanwhile, liberal and conservative opinions on the best way to provide sex education remain sharply divided. These differences concerning sex education, and who is best qualified to offer it--including whether parents or schools ought to serve as the primary sex educators--include whether parents or schools must

be the primary sex educators. Both parents and schools however give sex education through both informal and official instruction, respectively.

2.2.3.1 Sexual Education

Sexual education and sexual socialisation coexist. To begin, schools have a critical role in encouraging teenage sexual and reproductive health. Science subjects are critical in directing the creation of school health policy. Schools provide an effective and practical means to reach out to young people with health information and services. As they serve kids from all socioeconomic backgrounds, public schools may educate and serve children and teenagers who might not otherwise have access to education and services. Kagesteen et al. (2017: 27) report that while most young adolescents in developing countries have not initiated sexual intercourse, many are looking into intimate relationships, and the majority are doing so without having the knowledge needed to make informed decisions about their SRH.

These findings underline the importance of medically correct, comprehensive, and age appropriate SRH information and education for young adolescents. As the majority of young adolescents have only recently reached puberty as well as not yet engaged in sexual activities, the years 10-14 provide an appropriate window of time to provide complete sexuality education (CSE), and thus prepare very young adolescents to make informed decisions about their partners' health once they initiate sexual relationships. Schools, therefore, provide an important chance to educate young people about health and sexuality before they engage in health risk behaviour Consequently, schools can assist young people to build healthy practices that last into adulthood. According to Kagesteen et al. (2017:27), sexuality education provides an opportunity for every adolescent to explore relationships with others, learn about their bodies, comprehend human production, and develop a positive sense of self, all of which are essential components of healthy adolescent growth as well as laying the groundwork for future sexual and intimate relationships.

In addition to sex education, these teenagers require puberty education. Given that puberty frequently occurs between the ages of 10 and 14 (particularly among girls, who reach puberty earlier than males), this is an ideal period to educate young people about puberty-related themes (Kagesteen et al 2017:28). Girls and boys in many underdeveloped nations are unprepared for the physical changes that occur with the beginning of puberty. According to studies, many girls have no concept of what is happening to them when they begin menstruation (Kagesteen et al.,

2017:28). Menstrual hygiene and management, male puberty (spermarche), fertility, and awareness of one's body may all be covered in puberty education.

Unfortunately, most youths and adults do not receive sex education, and programmes that do exist frequently teach nothing more than knowledge about procreation, contraception, and STIs. Evidence suggests that well-targeted sex education can reduce risky sexual behaviour, albeit primarily in industrialised countries. Gender roles, self-esteem decision-making, domestic and sexual abuse, communication, and bargaining skills should all be included in the curriculum (Tsui et al., 2007:42). Similarly, Tolman (2003:4) observes that teenagers require the enactment of the universal right to sexual health as well as education and skill training that transcend learning to say no to sexual intercourse. Advancing sexual health among teenagers necessitates an awareness of the links between relevant parts of the developing self (e.g., self-esteem, and sexual expectancies), and the various contexts in which such development occurs (e.g., interpersonal encounters).

2.2.3.2 Sexual Socialisation

Sexual conduct and performance are influenced not just by biological reasons but additionally by sexual socialisation. Family and society are important institutions in this approach (Raziyeh et al., 2013:221). Families function inside civilizations, and just as families impact people's sexual behaviour, so does society. This usually takes the form of norms and expectations (Anarfi et al., 2010:6). In Malawi where communal interdependence is popular, what people say or believe about an individual has a significant impact on that person's behaviour. Every civilization has its own set of values, which are filled with incentives and punishments. While those who uphold excellent principles are praised, those who violate them are sanctioned or punished. This means that sexual socialisation also takes place outside the home as children and adolescents observe community norms, consume mass media, and participate in cultural and religious activities.

Additionally, learning concerning religious ideals, which might involve views of sexuality as a divine gift and sex as limited to marriage is part of sexual indoctrination. Children and adolescents are also exposed to a range of cultural perspectives on abortion, contraception, and gender roles. Such topics are sometimes left unresolved in schools because teachers are hesitant to investigate these varied viewpoints for fear of being viewed as advocating or disputing

specific religious and cultural norms. Exploring and comprehending both family and community impacts on sexuality, on the other hand, is an essential component of sexual education (Ronny, 2007:116). Sex education can help with psychological development, and well-being throughout adolescence and adulthood by fostering sexual literacy. The absence of sexual literacy can be the source of many health and social hazards, including STIs and unintended pregnancy.

As important as socialisation of sexuality is in orienting teenagers on sexual concerns, it can present certain hurdles to good interaction between parents and adolescents. According to Abdallah et al. (2017:46), five impediments to interaction between parents and children on sexuality exist in East Africa. They are gender disparities, traditional norms, religion, parental education levels, and occupation. In terms of gender disparities, mothers communicate with girls more frequently than with boys, while fathers rarely communicate with girls more frequently than boys. This further agrees with an observation made by Anarfi et al. (2010:3) that sexual socialisation in any community is inextricably tied to gender socialisation in that society. Overt sexual socialisation is often conducted during the customary preparation for marriage in various African countries. Even during such occasions, the emphasis is on sexual socialisation particularly emphasising on what the bride should do, and should not do (Anarfi, 2010:4).

Notably, parents' educational levels enhance communication between them and their adolescents on sexuality and reproductive health issues (Xiao et al., 2011:55). This suggests that the educated parents have more tolerance to converse orally and face-to-face with their children than the less-educated, or uneducated parents. Furthermore, they can communicate with their children in ways other than in spoken or face-to-face communication. Giving their adolescents, or children some learning resources such as books on sexual themes is also noticeably absent among parents with little or no education. Similarly, Mpondo et al. (2018:45), who conducted research in South Africa found that adolescents and young adults described conversations with their mothers as often being one-sided; with the mother doing the talking, and the daughter was expected to follow directions. Furthermore, the young ladies described their mothers as using phrases like "you have grown old now," "do not enter the kraal," and "don't sit on a chair or next to men" (see Mpondo et al., 2018:45). According to those young ladies, all these expressions had both literal (they were required to follow these rules) and hidden meanings (it may be that teenagers were barred from having penetrative sex).

Furthermore, the young women noted that dictums were utilised by elders in prior generations as part of *intojane* (a tradition that marks entrance into adulthood) to give directions on how to act as a young woman. Adolescents and young adults also expressed that they interpreted the dictums based on their comprehension because their mothers did not clearly explain the meaning of these idioms. This will be covered in greater detail in the next chapters on how culture influences sexual reproductive health. Religious beliefs are therefore frequently perceived as a barrier to dialogue between parents and adolescents about sexuality and reproductive health. Some faiths forbid their adherents from engaging in fornication before marriage, from performing abortions, and from using condoms (SRHR Policy, 2017:17).

The other obstacle for parents to discuss sexuality and reproductive health issues with their children is their work. As many self-employed parents return home on a regular basis, they may have time to talk with their children (Hilbrecht & Lero, 2014:27). This is in contrast to individuals who work for the government, and thereby have little time to spend with their children.

The previous discourse demonstrates the importance of addressing socio-cultural sociocultural norms and religious beliefs that obstruct good parent-adolescent dialogue on matters of sexuality and reproduction. Furthermore, schools must take the initiative in providing balanced information to students. This may also encompass issues with human rights, development, and, lastly, health. As a result, sexual reproductive health necessitates a multifaceted approach to address its multifaceted concerns.

2.2.4 Youth, Sex, and Media

An unguided youth lifestyle is one of the characteristics that affects SRH among youth, and this debate centres on how youth culture affects the sexual lives of adolescents. It investigates variables that may need to be addressed in order to better the sexual lives of youth in the church. The mass media is extremely significant in socialising communities all over the world. As novel methods of communication and media take on new forms and techniques, there is a trade-off between society becoming more educated and some vulnerable groups being exposed to harmful information that influences values and lifestyle behaviours.

Adolescence is sometimes defined as a pivotal period in the life cycle during which values are instilled and media use becomes more important. Music has been acknowledged as a significant element of adolescent life as well as a source of sex education. In the United States of America

(USA) for example, there has been extensive research on the many ways in which forms of media, particularly music, has had an impact on SRH attitudes and behaviour (10-16). A survey conducted in 2011 indicated that 42% of compact discs contain sexually explicit lyrics, and adolescents were the primary users of this media. The study also discovered that, regardless of social influence, family and religious connections, a high media diet was associated with higher sexual activity and/or intention to engage in such activities (Holder-Nervins et al., 2011: 159).

In South Africa, music is important in sexual socialisation because it conveys gendered and sexual orientations, while also producing cultural practices that produce such identities (Macleod. et al., 2015: 92). Blouse (2012: 53) in a study found that, aside from dancing and music, having fun in kwaito culture mostly centred around sex. Some critics argue that kwaito's most recent acts are oversexed, devoid of intellectual lyrical content, and imbued with crass industrialised sexual cliches in dancing style, attire, and melody. Some female artists and/or dancers offer no room for interpretation (Blouse, 2012:12). Holder-Nervins et al. (2011:159) for instance claim that the Caribbean region has a rich musical legacy, with some genres containing sexually explicit lyrics. It is important to understand the effect of music on sexual knowledge, attitudes, feelings, and practices. Most young people appreciate and prefer this type of music, which drives them to participate in premarital sexual behaviour after being initiated by such dances. This causes the youth to disregard both religious abstinence teachings, and cultural virginity beliefs. Aside from peer pressure, sexual education, and traditional practices; the youth learn about sexual reproductive health through popular culture, including music. This makes it difficult for the youth to obtain accurate information regarding sexual reproductive health, putting many young people at risk.

Popular media, such as the internet, music, and television frequently generate concerns because they add to unqualified exposure of adolescents to sexual knowledge, sometimes with more harm than good. Due to the multiple routes that the media employs to communicate sexual knowledge to children, the media has surpassed parents, educators, and socialisation agents. As a result, when discussing sexual reproductive health, we must address the influence of the media in sexual reproductive health among young people. The extent to which music influences the sexual lives of young people should inform the church about other various places where young people are influenced and advised on sexual topics.

2.2.5. Development Dimensions

This section discusses how sexual reproductive health is related to development, and how it may influence or affect the development process. It further investigates factors that may be considered in promoting or negatively affecting sexual health life among the youth. The discussion also gives proper guidance on this research, and how it may address the need for a church to break the silence on sexual reproductive health.

Sexual reproductive health is more than just a public health and rights concern. It is also an issue of development. This was also emphasised in the 2005 Millennium Project Report to the UN Secretary-General, "Investing in Development: A Practical Plan for Achieving the Millennium Development Goals (now known as Sustainable Development Goals)". The paper urges the inclusion of SRH issues in national, regional, and worldwide poverty-reduction initiatives, claiming that SRH is critical to achieving development goals. (Nkruma 2019:76).

According to Nkrumah (2019: 78), reproductive health promotes numerous development outcomes via demographic dividends. Adequate and equitable access to enhanced reproductive healthcare, sexually transmitted infections (STIs), and improves pregnancy outcomes with broader individual, family, and societal advantages. Such advantages may include a healthier and more productive workforce, as well as higher financial and other resources for children, particularly those from smaller homes. On the contrary, negative reproductive health outcomes (early and unplanned pregnancies, greater levels of fertility, poorly managed obstetric problems) might hinder prospects for impoverished women and their families to overcome poverty.

Furthermore, access to appropriate and high-quality reproductive health services is linked to the attainment of key SDG targets. This shows that appropriate and equitable access to reproductive health services is critical to meeting both health-related and non-health-related SDGs (Nkhruma, 2019: 8). Newman et al. (2015:58) explicate further that sexual reproductive health rights, like climate change, water, and sanitation, contribute to development in the same way. Newman et al. (2015:58) add that sexual reproductive health rights may contribute to population control, urbanisation, immigration, ageing, and population increase, as well as concern for respecting, fulfilling, and preserving human rights. It is pertinent that member countries should focus on the five core aspects of reproductive health and sexual health to attain millennium development goals by improving antenatal, perinatal, postpartum, and newborn

care. Focus should also be on promoting sexual health as well as providing high-quality services for family planning including infertility services; eliminating unsafe abortion, combating sexually transmitted infection including HIV/AIDS, reproductive tract infections, cervical cancer, and other gynaecological morbidities.

Due to the tight linkages between the many facets of reproductive sexual health, interventions in one area are likely to have a good impact on the others. Countries must reinforce current services and use them as the entry points for new interventions to maximise synergy (WHO, 2004:13). Resultantly, sexual reproductive health care services require adequate attention to deliver these critical services. In exchange, governments may save money on drugs for chronic conditions such as HIV and other infections. At the family level, SRH will allow people to focus on their fields or enterprises to contribute effectively to the country's economy rather than spending the majority of their time caring for the sick. Furthermore, small families are easier to feed and provide general welfare care for than larger families. It will be easier for the government to deliver quality services to its residents if the country has a controlled population as a result of a meaningful sexual reproductive health program among the youth. This would be important in developing the country and its economy.

2.4. Determinants of Sexual Reproductive Health

As described in the literature studied, there is a complex range of factors that contribute to Sexual Reproductive Health (SRH) barriers, particularly among teenagers. Self-determination and choice, access to educational and therapeutic resources, societal-cultural practices, social stigma, discrimination, and sexual assault are all examples of sexual impediments to sexual health/well-being. Even professional medical education does not convey sexual health and sexual medicine skills, and confidence (Sathyanaraya, 2012:105). Below are some of the obstacles.

2.4.1. Social, and Cultural Determinants

Social and cultural norms are very important in SRH. Women's SRH are determined not just by their gender, but also by their sex. Gender determines what role one plays while making decisions about sexual reproductive health based on cultural standards. Besides that, being a male or a female has implication on SRH methods. This cultural theme is covered in chapter 5.

Beliefs

Some contraceptive techniques, such as condoms are critical in preventing pregnancy, STIs, and HIV. This dual protection feature of the condom appears to have been underutilised in Malawi. Many societies have cultural norms and beliefs that discourage the use of condoms, including religious infidelity. Some people believe that using a condom prevents them from having intercourse (Bisika, 2008:80). Some churches also preach against the use of condoms as wicked, especially among unmarried young people. Instead, they would rather advocate abstinence, which is difficult for some young people to achieve.

Similarly, Palamuleni (2013: 93-94) observes that religious affiliation influences contraceptive use. Religions differ in their approach to birth control, and among the major world religions. Catholicism and Islam are commonly recognized as pronatalist in their theology. Nonetheless, the intensity of one's religiosity or degree of devotion to the standards of a certain religion may have an impact on one's way of life, including reproductive behaviour. Beliefs and religion are examined further in Chapter 3.

Importantly, Attitudes play a role in sexual reproductive health as well. In contrast to modern cultures, most traditional African societies are built in such a way that high fertility and big families are advantageous. African civilizations may be resistant to contraception and fertility control in this situation (Palamuleni, 2013:94). Based on this view, many people have huge families that they cannot take care of, resulting in higher poverty levels in the families. In other cases, failure to care of these families jeopardises the life of a girl child. For example, if a school going girl is not taken care appropriately, the girl might look for easy options such as dropping out of school, engage in prostitution, and early marriages. These decisions might have long term impact on the lifetime of the girl child Owing to economic constraints; and boys, too, are often compelled to marry before they are ready.

Gender and cultural views regarding reproductive health are yet another obstacle to sexual reproductive health. It is assumed that sexual reproductive health is primarily a female concern, and men are not permitted to accompany their spouses to the clinic (Gombachika et al., 2012:6). Gender, on the other hand, is a social construct. Gender is what it means to be male or female in a specific community. Gender traits include norms of behaviour regarded proper for each gender and a distribution of labour between the two. There are traditional ways of family planning in addition to modern contraceptive methods. Traditional methods of contraception

for women include wearing (mkuzi) beads waist rings with medicinal virtues believed to prevent pregnancy (Palamuleni, 2013: 95; Maliwichi & Nyirenda, 2010: 233). Another includes women inserting some medicinal herbs into the cervix to prevent pregnancy.

In general, it appears that in developing nations, social, cultural, and religious unacceptability of contraception arises as a barrier to its usage. These countries, however, have agreed to international policies that promote universal access to sexual and reproductive health care. Despite having signed some international regulations on access to reproductive health treatments, several countries are having difficulty enforcing these laws due to cultural tensions within their own civilizations. Condom use, for example, has met strong opposition in various societies. This discussion demonstrates the importance of properly implementing these SDGs, which must be consistent with people's religious and social-cultural ties rather than imposing theories on them.

Illiteracy levels

Gombatchika et al. (2012: 5) assert that high illiteracy levels in Malawi also cause people to lack a clear understanding, appreciation, or patronage of sexual reproductive health services. In Sub-Saharan Africa, the discrepancy between urban and rural contraception uptake is the greatest (Palamuleni, 2013: 92). Guyete et al. (2015:191) note that less-educated women do not understand how their bodies work and do not want to utilise current contraceptive techniques due to misconceptions about them (e.g., some women believe they would become permanently infertile). This means that the higher the literacy level, the higher the use of contraception methods. Contrastively, lower literacy levels result in lower usage of contraception.

There is another myth concerning family planning in Malawi. Many societies believe that intercourse should be avoided during menstruation. As some contraceptive methods might cause prolonged bouts of bleeding, some women may refuse to use them for the fear of keeping their husbands waiting for longer durations, which may encourage some men to seek sex elsewhere (Bisika, 2008:80). Furthermore, there is a societal expectation that people living with HIV will not require reproductive health treatments. This is because reproduction is viewed as a risk factor for HIV-infected people. This has led to self-discrimination, and to avoid social disgrace, many people living with HIV do not want to be seen in settings where such services are provided.

2.4.2. Behavioural Determinants

Health is a human rights concern that can in most case not be met, even though it should have to be provided and met accordingly. Health issues are more in the hands of the individual than the physician. Unsafe sex is one of the most serious global health risks. Sexual and reproductive behaviour has far-reaching health repercussions if there is negative behaviour. Individuals must be provided with information and should be empowered to act on that information to protect their health. Furthermore, the behaviour of others can have a negative impact on their health. Culture remains a major behavioural influence, and adolescents are frequently denied sex education when their developing capacities are ready for it, and they require it. Observably, many adolescents do obtain information, or more typically, disinformation, from their peers when this education is not available through school, church, or home (Synod of Livingstonia Strategic Plan, 2008:39).

According to Uchudi et al. (2012: 292), because actions are governed by socially organised institutions and assumptions rather than instincts, t involvement in high-risk behaviours is likewise determined by community features. This ecological argument emphasises the fact that human behaviour cannot be understood unless it is evaluated in the context of the larger social context in which it occurs. In agreement with the above attitude, Wadesango et al. (2011:125) note that some cultural and traditional practices support underage marriage. Some groups in Malawi's central and southern areas have a cultural practice known as "fisi," meaning "hyena," which is mainly performed at initiation ceremonies. Based on this practice, when a girl hits puberty, she must experience a type of sexual purification as a rite of passage from childhood to adulthood. A girl is given a man to sleep with as a test of her womanhood in this ritual. If she becomes pregnant during the ceremony, she may be forced to marry this man because having a child out of wedlock is embarrassing (Bisika 2008: 80; Rembe et al., 2011:67; Palamuleni, 2013: 93).

Gender expectations in some societies across the world require that females marry, and start having children in their early or middle adolescent years, well before they are physically or mentally ready to do so. Early marriage puts individuals at risk of a variety of dangers, including high-risk pregnancies and deliveries, intimate partner abuse, and HIV transmission. Adolescent females have less power in many contexts to negotiate safe sex with their partners,

especially if they are in relationships involving the trade of sex for money or favours due to economic motives.

The Ngonde people of northern Malawi have a cultural practice known as "kupimbira." This practice involves parents borrowing money, or a cow, and promising to give them a girl child if they are unable to repay the borrowed money or cow (Rembe et al., 2011:67). This approach not only encourages early marriages, but also puts girls at risk of marrying older men just because they are wealthy. This is also a violation of a child's rights.

There is a complex set of factors that contribute to SRH problems in adolescents and especially in adolescent girls. Worldwide, children are reaching puberty earlier and marrying later than their parents' generation. Contextual factors such as the pressure to conform to popular media stereotypes, and the norms of their peers as well as impaired judgement resulting from the use of alcohol and other psychoactive substances, make adolescents more likely to expose themselves to risks.

Noticeably, many adolescents become sexually active at an early age when they do not know how to avoid STIs, and unwanted pregnancies. At an individual level, because girls' bodies are still growing and developing, pregnancies in early adolescents are associated with greater risks of obstructed labour. Girls are less likely than males in many situations to receive an education, necessary health care, and the ability to grow and develop before taking on adult tasks. As a result, females are more vulnerable to the consequences of poor sexual reproductive health behaviours than boys.

2.4.3. Health System Determinants

For most of the world's population, SRH services remain inadequate. There may be an imbalance between urban and rural services, between curative and preventive care, and between infrastructure development and health workers where they are available. Another important element is the affordability of services (WHO, 2011: 12). Africa's health-care systems differ from one another. Their effectiveness varies depending on whether they are in an urban or rural setting, and if they are in a government or mission hospital. Some remote locations have inadequate health infrastructure, although appropriate equipment is accessible. Another problem is a lack of medical personnel in rural clinics. Adolescents' susceptibility to

poor SHR is exacerbated by a lack of youth-friendly services, and health products as well as a lack of knowledge and information about safe sex and contraceptive use (WHO 2019:5).

A research carried out in Malawi , most youth would prefer to seek treatment for STIs from traditional healers rather than a clinic or hospital(Munthali et al 2004:24). They believe that traditional healers are guaranteed privacy when seeking therapy. Youth at healthcare institutions are afraid of being humiliated by hospital workers (Munthali et al., 2004: 24). Furthermore, even when SRH services are provided, they are frequently inconvenient, unacceptable, or inaccessible to young people (Munthali et al., 2004:24). Furthermore, in most situations, facilities offer services to both adults and adolescents. This often put the majority of the adolescents into disadvantages since they might not be free to interact with adults (Munthali et al., 2004: 24; MDGS, 2015-2016).

Moreso, inadequate medical facilities contribute to inadequate sexual health, and reproductive services in some rural locations. This means that most rural hospitals have insufficient equipment, and they are equally experiencing poor road network, thus making a simple transit stressful. These circumstances make it difficult for those who require sexual reproductive health services to access them. The unavailability of these facilities in health care systems continues to be a barrier to sexual and reproductive health.

2.5 Consequences of Lack of Sexual Reproductibe Health

Complications occur because of a lack of SRH, some of which are lethal. There are numerous health risks that result from improper sexual reproductive management. This section therefore examines some of the most serious effects of a lack of sexual reproductive health.

2.5.1 Pregnancy, Childbirth, and Health of Newborns

Every day, an estimated 800 women worldwide die from pregnancy or childbirth-related problems, with the vast majority of these deaths occurring in impoverished countries (UNFPA 2017 :15; WHO 2012 12). Women in the industrialised world had a one in 3800 lifetime risk of dying from maternal cases, compared to one in 150 in developing nations, and 39 in Sub-Saharan Africa. For every woman who dies as a result of a pregnancy-related cause, an estimated 20 others suffer from maternal morbidity, which can include serious and long-term problems. Access to good maternal health care is severely inequitable across regions and within

countries, with poor and wealthy women experiencing significantly different levels of access (WHO, 2012: 15).

Similarly, child survival has made significant progress. In 2012 however, an estimated 18,000 children under the age of five perished every day (UNICEF, 2013: 13). Deaths among children under the age of five are becoming more concentrated in Sub-Saharan Africa, and Southern Asia. Undernutrition is also responsible for around 45% of fatalities among children under the age of five worldwide. As there are drops in the mortality rate for newborns are slower than those in the mortality rate for older children, the proportion of under-five deaths that occur throughout the first month of life (neonatal period) has been growing. The majority of newborn deaths occur within the first few days of life. In addition, an estimated 3.3 million babies are stillborn. The majority of these deaths are connected to a woman's poor health and inadequate care during pregnancy. Furthermore, a mother's death can seriously compromise the survival of her child (UNICEF, 2013:13).

2.5.2 Insufficient Family Planning

Birth control is an important aspect of sexual reproductive health. It aids in the prevention of unplanned pregnancies, and risky abortions. Both individuals and couples are able to plan and achieve their preferred number of children as well as the timing and spacing of their births, through family planning. Individuals and couples must use a specific form of birth control to accomplish this.

Contraceptive use has skyrocketed in several underdeveloped countries. According to a recent systematic review, global use of contraceptives increased from 54.8% (95%) uncertainty interval 52.3%-57) in 1990 to 63.3% (60.5-66.0) in 2010 (WHO 2014:3). Except for those where the use of contraceptives was already high in 1990, nearly all sub-regions saw a rise in contraceptive prevalence. Despite their declared wish to avoid or space pregnancy in the future, an estimated 146 million (130-166 million) women globally aged 15-49 years, and who are married or are in a union had an unmet demand for safe and effective contraception in 2010. Unmet demands were estimated to be greater than 25% in 42 nations, 29 of which were in Africa. Among the 208 million women expected to become pregnant each year worldwide, 59% (or 123 million) had a planned or unplanned pregnancy that resulted in birth or stillbirth. The remaining 41% of pregnancies (about 85 million) were unplanned (WHO, 2012:12).

Reproductive health entails not only the ability to choose if, when, and how frequently to have children, along with the ability to reproduce. Infertility is a public health and social issue, particularly in countries where children are the only goods a woman is required to provide. Due to cultural norms and religious beliefs, family planning initiatives appear to be a foreign and contentious activity in Africa. It is facing several hurdles in terms of its implementation and acceptance in various areas of society, offering a challenge to the youth. This is examined further in the coming chapters on how cultural behaviours relate to sexual reproductive health.

2.5.3 Unsafe Abortion

An unsafe abortion is a "procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal standards, or both" (WHO, 2017:7). Induced abortion is the oldest and most often used method of fertility management. Few nations have been able to look objectively at the health implications of abortion as they affect women since it touches on some of the most profound religious and social concerns. Lack of contraception is a major cause of an unplanned pregnancy. Other risks include contraceptive failure, coercion, or rape; young age, a woman's lack of control over contraception, abandonment, or an unstable relationship (Kumari et al., 2018:27).

Relatedly, Okonofua (2006:975) mentions that factors linked to increased maternal mortality from risky abortions in developing countries include insufficient contraception methods, prohibitive abortion laws, pervasive negative cultural and religious views regarding induced abortion, and inadequate health infrastructures for the management of complications. Annually, an estimated 22 million abortions are done in dangerous conditions around the world. Every year, over 47000 women die because of complications from unsafe abortions, and an additional 5 million are permanently crippled (Fathallah & Cool, 2012:14; WHO, 2011: 7).

Access to safe elective abortion is limited, accounting for approximately 13% of all maternal deaths. Legal considerations also influence whether women with unwanted pregnancies get a safe or unsafe abortion. Nearly 20% of women between the ages of 15 and 44 live in countries where abortion is not legally permitted to save a woman's life (WHO, 2011:7). In countries such as Pakistan where abortion is illegal, and there is a significant unmet need for family planning, couples are more likely to resort to a clandestine abortion to terminate an unwanted/unplanned pregnancy as a method of choice to reach their desired family size. The

profile of a Pakistani woman opting for, or admitted for complications of abortion is married; multifarious (average 4 children), and in their 30s as reported from community and hospital-based studies (Kumari, 2016:27).

As observed by Shah et al (2014: 39) when faced with an unwanted pregnancy, women all over the world are more likely to have an induced abortion, regardless of legal circumstances. Where abortion laws are liberal, there is often no or very little evidence of unsafe abortion and attendant morbidity or mortality. Legal constraints, on the other hand, lead to women self-inducing abortions or seeking them clandestinely. These abortions are illegal and generally dangerous (Shah et al., 2014:39). The criteria under which induced abortion is permissible vary by country. Abortion is illegal in some nations but allowed in others. Abortion was legal in 97% of 194 countries in 2011, the most recent year for which data is available. Among the 194 countries, 49 countries allow abortion exclusively to save a woman's life. For others, the law is not unambiguous; hence, access to abortion can be challenging. Relatedly, abortion regulations vary, and can be difficult to execute, obey, and evaluate its effectiveness in many societies.

In summary, unsafe abortion is a threat to human life considering the above statistics, and complicated abortion laws discussed above. One can easily declare unsafe abortion as a human war.

2.5.4 Sexual Transmitted Infections

Some infections spread mostly through sexual contact, especially vaginal and oral intercourse. Some STIs can be transmitted non-sexually as well through blood products, for example. During pregnancy and childbirth, many STIs (including Chlamydia, gonorrhoea, hepatitis B, HIV, and Syphilis) can be passed on from mother to child. Sexual contact is known to transmit over 30 different bacterial viruses and parasites (WHO, 2017: 7).

Sexually transmitted infections are a big public health issue. In 2008, the total number of new infections of four curable STIs in individuals aged 15 to 49 was predicted to be 498.9 million. Among these cases, 105.7 million were cases of C trachomatis, 106.1 million cases of N. gonorrhoeae, 10.6 million cases of syphilis, and 276.4 million cases of T. vaginalis. Furthermore, in 2008, it was determined that 100.4 million persons got infected with C. Trachomatis, 36.4 million with N. gonorrhoeae, 36.4 million with syphilis, and 187.0 million

with T. Vaginalis (WHO, 2012:4). Many cases go untreated because they are difficult to diagnose, and skilled, inexpensive services are scarce. They can, among other things, be a major cause of infertility in women. If instances of primarily incurable viral illnesses are included, the annual number of sexually acquired viruses could well approach one billion (Glassier et al., 2006:17).

As discovered, sequally disseminated human poliovirus disease is intimately connected to cervical cancer, the second most frequent malignancy in women globally, with around 500,000 new cases and 250,000 deaths per year (WHO Dept of Making Pregnancy Safer, 2006: 13). Almost 80% of cases occur in low-income nations where screening and treatment systems are poor or non-existent. Currently, two HPV preventive vaccines are widely available on the international market; both vaccines are designed to be provided to females before the initiation of sexual activity, that is, before the first exposure to HPV infection (WHO, 2009:32). Vaccines are expected to have a major impact on the future burden of cervical cancer. Socio-cultural health systems and political barriers to expanded access will need to be overcome particularly in low- and-middle-income countries (Wingletet et al., 2013: 32).

Moreover, women account for 52% of all HIV patients in low-income countries, while men account for 48%. In Sub-Saharan Africa (the epicentre of the worldwide pandemic), women continue to account for around 57% of all HIV-positive adults. Furthermore, non-sexually transmitted reproductive tract diseases such as bacterial vaginosis, and genital candidiasis are known to be common, while the prevalence and implications of these illnesses are unknown (UNAIDS, 2013: 13). Sexually transmitted illnesses are difficult to combat because many people are reluctant to disclose their infection status for fear of prejudice and harsh judgement. Some individuals also equate any STI with immorality, which is not necessarily the case. There is a need therefore to advocate for proper sexually productive health communication, especially among the youth within, and outside the church.

2.6 Conclusion

Sexual reproduction is a complicated, and complex process that necessitates a varied strategy that includes the faith community. Sexual reproductive health touches many human social constructions, including health, rights, religion, social-economic/cultural aspects, and development. The biggest obstacles to sexual reproductive health are a lack of family planning as well as the absence of contraception, the occurrence of STIs, and unsafe abortions. If not

managed appropriately, these can be lethal. If not addressed, these difficulties may have a severe impact on the social-economic growth of the family and nations. As previously noted, there are some impediments to sexual reproductive health such as weak health systems, social-cultural norms, and literacy levels.

The primary goal of sexual reproductive health is to prevent poor SRH such as pregnancy, and childbirth problems; unwanted pregnancies, unsafe abortion, STI complications, sexual abuse, and women dying from preventable cancer. Furthermore, inadequate treatment of sexual reproductive health may lead to many young people dropping out of school and entering early marriages. In turn, these young people may not contribute meaningfully to the development of the country if they drop out of school or marry earlier. This may exacerbate the poverty cycle.

Largely, youth culture and the media are two elements that contribute to poor sexual reproductive health among adolescents. Another cause is a lack of proper sex education in schools, which emphasises rights at the price of youth dignity. All of this might be easily avoided if all stakeholders, including religious bodies join forces to combat barriers to sexual reproductive health. Religion and culture are two of the above-mentioned impediments to sexual reproductive health. The next chapter focuses on how sexual reproductive health are perceive from a cultural and religious perspectives.

CHAPTER 3

SEXUAL REPRODUCTIVE HEALTH IN THE CONTEXT OF MALAWIAN SOCIAL CULTURAL PRACTICES

3.1 Introduction

This chapter investigates how sexual practices and sexual health among the youth are perceived in most Malawian social and cultural practices. The discussion is limited to those tribal cultural practices related to this study that have been found in the literature accessed by the researcher. The discussions specifically pay attention to how social sexual cultural practices among the youth affect and influence the sexual life of the youth. The specific focus areas are on initiation ceremonies. The discussion also critically analyses the advantages and disadvantages of initiation ceremonies. Furthermore, the chapter also explores types of marriages and possible reasons for marriages, and how initiations and marriages affect the social economic status of the youth. This chapter further seeks to investigate how some cultural values may have influenced church doctrines or traditions that relates to SHR.

In addition, this chapter presents Malawi Government policies that are against harmful cultural practices in Malawi. This chapter only looks at the detrimental cultural behaviours associated with sexual practices. The conversation continues to criticise how these policies are executed in order for the church to use the policies as the backdrop for this research. These policies are debated in accordance with international policies to which the Malawian Government has agreed. This will help to direct the research on how the church can help to implement activities against these detrimental cultural behaviours in order to answer the research question of this study.

Before delving into Malawian sexual cultural practices, this study provides a general summary of several sexual cultural practices in some African countries based on research. The following discussion seeks to highlight some similarities, and contrasts with Malawian sexual cultural practices.

3.2. Youth's Sexual Cultural Practices

Phiri (1997:12) states that it has been long accepted that one can talk about African Culture in the singular because of the diversity found among African peoples. Furthermore, many similarities in the cultures of Africa make it possible for one to talk about African Culture in the singular (Phiri, 1997: 12). Culture is defined as people's expression of their behaviour towards one another, religious beliefs systems, and practices, language, symbols, customs, art, music etc. (Phiri, 1997:12). This study explores some cultural practices in Central and Southern part of Malawi to give a picture of some sexual initiations done in Malawi. Limited literature however is available discussing initiations in the Northern Malawi that also formed part of the study.

This section focuses on a few selected African cultures that were accessed in the literature during this study. This discussion presents a brief background and overview of how some African sexual cultural practices are similar and different from Malawian sexual cultural practices. It is worth noting that Africa seems to have a similar way of handling the sexual life of the youth as observed in the following areas highlighted from different literature the researcher came across.

3.2.1 Sex-Silent Culture

According to the literature studied during this research, most parents in African cultural traditions practise a silent culture on sexual problems among young people. They prefer having a third party discuss sex problems with their children. In a recent study conducted in South Africa by Motsoni et al., (2016:3), parents expressed fear that discussing sex and sexual reproductive health issues may push their children to engage in sex. Parents were embarrassed to discuss STIs, condom use, and pregnancy prevention methods with their children because they were too young to understand all of these sensitive matters. Furthermore, Motsoni et al., (2016: 3) further reported that respondents believed that sexually transmitted infections were diseases for adults and that there was no use in discussing such matters with children. They also contended that as the youth become adults, they will be aware of this (Motsoni et al., 2016:3). In Ethiopia, it is considered culturally humiliating for parents to discuss sexual reproductive health issues with their children. Lack of sufficient understanding regarding SRH, and its associated socio-cultural taboos make open dialogue of SRH issues between parents and young people problematic (Ayetu et al., 2016:2).

Similarly, research conducted in Ghana at Bolgatanga Municipality established that a few respondents claimed that their parents talking to their children about the topic of unprotected sex can have unforeseen and unwanted implications (Geugten et al., 2017:1049). It was also discovered that only a tiny percentage of educated parents discuss SRH with their children while others send them to the health clinic for SRH instruction. Aside from parental understanding of SRH, discussing SRH-related concerns with children is still frowned at. It is regarded as unethical, and it is feared that it would inspire young people to engage in sex.

Geugten et al. (2017:1049) notice that young people in today's world do not obey their parents. They seek help from friends rather than their parents for sexual difficulties, and they do what they want. In most situations, people receive incorrect guidance, which leads to unforeseen consequences. Furthermore, a study conducted in Egypt on youth knowledge and attitudes around sexual reproductive health found that girls (282 females versus 426 boys) were less likely to address sexual-related issues with their parents. Furthermore, females were less likely to feel competent while addressing sexual reproductive health topics at school (Menshawy et al., 2020:3).

Notwithstanding, some researchers had observed that parents are more likely to discuss sex with their children if they have a strong relationship, and communicating well with their child, which is frequently used as a proxy for relationship quality. According to Ritchwood et al. (2018:2208), a deeper parent-teen relationship and a more open communication style may assist teenagers to better comprehend their parents' attitudes and ideas concerning early sexual engagement. Failure to communicate sensitive sex matters may lead children to assume that certain topics are off-limits, and should not be discussed, thus influencing future sexual relationships (Ritchwood et al., 2018:2211).

Parent-led sexuality education is thought to allow parents to deliver sexual health information to their children in a way that is consistent with their values and beliefs. Furthermore, unlike school-based programmes, parents can personalise this material to their child's early teenage life experiences as well as the social and communal setting. They can also exert effect throughout teenage development, influencing youth behaviour and attitudes in a variety of circumstances (Ritchwood et al., 2018:2211). This technique could be beneficial if churches can also urge parents to talk to their children, despite cultural norms.

Some studies have found that adolescents who talked sex with their parents were less likely to participate in risky sexual conduct. In Kenya, initiatives such as "family matters" engage directly with parents, and their children to increase intra-family communication on sexuality and sexual risk (Wamoyi et al., 2010:2; Njoroge et al., 2010:146). Furthermore, there have been efforts in East Africa to investigate parent-child relationships, particularly parent-child communication. Uganda, for example, has investigated the utilisation of traditional techniques of socialisation (such as the *sengasega*) while programmes such as the straight talk campaign have showed the general readiness of parents and other adults to create a supportive atmosphere for young people (Wamoyi et al., 2010:2).

In agreement with the Ugandan approach to responding appropriately to the sexual reproductive health needs of the community, it is important to gain an understanding of the social and cultural contexts of people's lives. It helps further to identify needs within and in terms of such contexts. It also helps to identify gaps and where we can improve in the interest of improving the sexual reproductive health of the youth. The above discussion has shown some similarities of silent culture in some African countries. The following section explores how initiation is done in some cultures in Africa and how they relate to SRH education.

3.2.2 Initiations Rituals

Social Puberty Rites

Initiation rituals are symbolic, habitual, and repetitive events and actions that facilitate connections to the most valuable aspects of life (Kyalo2013: 35). Kyalo (2013:35) affirms that initiation traditions introduce youth to age grades. In other words, numerous African ethnic groups undertake social transition rituals, which commemorate an event in a person's life. The start of childhood as well as when and how a child moves into adulthood (rites of passage) differs between cultures and countries. The transition to adulthood in primordial societies frequently correlates with physical puberty or sexual maturity. Social puberty is therefore primarily concerned with the shift from the asexual world of infancy to adulthood defined by sexual roles (Kyalo, 2013: 39). The initiates must go through various ordeals to prove their capacity to take on their new obligations, as well as be instructed in the community's hidden knowledge and shown the sacred artefacts.

In the case of boys, this frequently entails circumcision or sub-incision, which entails cutting the underside. For girls, they are subjected to clitoridectomy rituals in various countries. It frequently includes a painful process of removing the clitoris.

Circumcision

Male circumcision is one of the most common operations in Africa, with a wide range of variations between locations. According to Lawal et al. (2017: 150), the time and cause for circumcision differs across the entire continent. Circumcision is mostly performed for religious reasons in the north and west of Africa, whereas it is primarily performed as a rite of passage into adulthood in the east and south. The prevalent practice of male circumcision in all cases nevertheless comprises the removal of a portion or the entire foreskin of the penis (Kang'ethe, 2013: 115).

Lawal et al. (2017: 150-151) had further discovered that traditional male circumcision based on cultural prescriptions takes place primarily in young men in Uganda, Tanzania, Kenya, and Swaziland. Similalry, Marck (1997: 339) reiterates that male circumcision seems to have been a widespread practice in practically all African countries. Circumcision is substantially more widespread in central inland east and inland southern Sudan as well as the lake region of southern Africa (Marck 1997: 339). Male circumcision is also usually connected with adolescent initiation schools, which in turn commonly specify age grades (Marck, 1997: 346).

Relatedly, Vincent (2008:43) contends that male circumcision practices symbolise the separation of man and woman, marriage preparation, and mature sexuality. In other respects, circumcision represents both death and rebirth as well as the demonstration of masculine fitness (Vincent, 2008: 433). The major purpose of circumcision is to teach males how to handle life in the future. They are taught how to deal with adversity, and the mature way of existence (Vincent, 2008: 433). In addition, the author states that the Xhosa of South Africa practice one of the most hidden and sacred rites when it comes to male circumcision. For instance, women and uncircumcised men are barred from learning about male initiation practices. According to Ntombana (2011: 632), the Xhosa community views circumcision initiation as a moral and ethical tradition. This means that the initiation is required to move from the stage of irresponsibility to the stage of responsible masculinity. Ntombana (2011:632) stresses further that only males who have undergone circumcision procedures may be acknowledged as men, and allow to participate in the Xhosa community.

While boys in the Xhosa society are circumcised, as previously described; girls have an initiation ritual. Common adolescent girls' rites are known as *Intonje* among the Xhosa people (Schroeder et al.,2022: 185). Girls are secluded from their communities during this rite of passage and educated about their bodies, cleanliness, menstruation, and other topics. This event is frequently performed in initiation schools, where the girls are forced to attend in order to show respect for traditional authority.

Female Circumcision

Female circumcision is practised in several areas of Africa. Johnsdotter, and Essen (2016: 16) affirm that academic scholars frequently refer to female circumcision as female genital mutilation (FGM). FGM can range from pricking the clitoris or clitoral hood to removing tissues. Kang'ethe (2013:115) describes the many varieties of female circumcision or FGM, including type 1-clitoridectomy, which is the least severe and involves the removal of the prepuce and clitoris alone, leaving most or all of the labia minora. Type 2 excision comprises clitoridectomy incision as well as removing sections or all of the labia minora. Type 3 is known as infibulation, and it is the most severe and extreme form of FGM. This involves the total removal of the clitoris and the labia minora as well as cutting away most of the labia minora to form raw edges that are stitched together, leaving only a small hole for the flow of urine and menstrual fluid. Pricking, piercing, or incision of the clitoris or labia, stretching of the clitoris or labia, and introduction of caustic substances into the vagina are all examples of type 5 practices (Kang'ethe 2013: 115; Johnsdotter, and Essen 2016:16).

The main motive for female circumcision, or FGM is to safeguard virginity and honour (Khaja et al., 2010: 686). These authors maintain that girls can be circumcised at any age, i.e., from one week to adolescence, according to local customs. Similarly, Wangila (2007: 29) observes that during initiation rites, girls are encouraged to desire early marriage and to be subservient to their husbands or risk physical discipline. They are encouraged to be good housewives and to endure in adverse circumstances.

3.3. Common Sexual Cultural Practices in Malawi

This section examines some of the social and cultural activities that influence the sexual health of Malawian youth. This investigation may not cover all sexual culture activities in Malawi, but rather only social cultural practices found in the literature linked to this topic. This section

looks at the many sorts of initiations and evaluate their benefits and drawbacks for the sexual and health lives of young people. The section also explicates how initiation rites affect the social-religious, and economic lives of Malawian youth.

3.3.1 Initiation Rituals

Initiation rituals are the most widespread practice related to lack of sexual reproductive health culture in Malawi. According to the survey report conducted in Malawi by Makwemba et al. (2019:57-58), the typical curriculum of the initiation rites across societies greatly ranges from teaching and counselling to sexual instructions and sexual practice. Other activities at the initiation rituals, such as counselling instruction and teaching excellent manners and housekeeping skills were also praised in the survey. According to the survey, girls' initiation ceremonies are significantly more common in the southern region than in any other region, and they are even more common in rural communities. Boys' initiation ceremonies are more widespread in the south, and common in rural areas. Other than the lessons outlined above, the most significant reason to take part in such initiation procedures is to follow traditions. It is also said that following traditions without added requirements while preparing for adulthood is shown. In other words, initiations try to preserve cultural identities while also teaching some social and life skills and preserving ancestral beliefs (Makwemba et al., 2019: 58).

The predominance of these initiation rituals varies according to culture, area, religious influence, and ethnic groups. In southern Malawi, for example, practically all villages undertake initiation rituals, and many villages are expected to participate in around 80% of villages. These rates are substantially lower in Malawi's north and centre. It is also noted that initiation is significantly more common in places with matrilineal kinship systems than in areas with patrilineal kinship structures (Makwemba et al., 2019:59).

The following sections explores some of the initiation traditions present in Malawi. The discussions are limited to the types of activities and behaviours performed at the initiation rituals. However, the discussion investigates how these activities affect young people's sexual reproductive health. It likewise xrays how these initiation rites may affect the social-religious and economic lives of young people. The observations obtained will be beneficial in answering the study's research questions.

3.3.2 Sexual Cleansing

The sexual cleansing technique is seen as a rite of passage, and it is conducted by a paid person known as fisi. Fisi is the Chichewa word for a hyena. It refers to a male who sexually initiates girls in order to complete their rights to womanhood (Banda & Kunkeyani, 2015: 3). Banda and Kunkeyani (2015:3) classifyy fisi into three types. The first type of fisi occurs when a couple is unable to conceive a child. The childless couple or family members identify a man to assist in the woman's pregnancy. The fisi plays his cultural function and has no rights to the child or children he fathers. The second type of fisi is when a girl who has experienced her first menstruation must engage in sexual intercourse with a man to complete her initiation into womanhood. This ritual is known as *kusasa fumbi*[1] (removing dust). The third sort of fisi ceremony occurs after a family member dies. To mark the completion of the mourning phase, a fisi is organised. The rite allows the widow to remarry if she so wants. Warria (2018:298) however adds the following fisi positions.

i. When a significant item for the house, such as a fish net for business is purchased, a fisi is hired to have sex with a female in the family to placate the spirits and the prosperity of the business.
ii. When a woman experiences a miscarriage, the fisi is also employed to purify the woman through sexual activity that is unprotected.
iii. Following the birth of a baby, the infant's mother, regardless of marital status, engages in unsafe sexual intercourse with a fisi in the belief that it will cleanse the baby and affect his or her healthy growth.

According to the above list, girls and women remain victims at various points of their lives, and that vulnerability is compounded by their gender, and the amount of fisi rites they perform. Girls who are induced by this practice are at risk of engaging in premarital intercourse, which could have an impact on their sexual reproductive health. More details about the susceptibility of women and girls depending on how these cultural norms affect gender is described in chapter 5 (section 5.3) of this study to provide guidance for answering the question at the heart of this study.

[1] Fisi sleeping with an initiate as a way marking the end of initiation preparing her for adult roles.

This traditional practice of old men having sex with young girls is practised in rural and isolated areas in Malawi. The reason why the ritual is referred to as (fisi) hyena is not clear (Warria 2018:298). Incidentally, Longwe (2003:41) notes that such a man is known as fisi (hyena) because he comes at night to steal, acting like the animal itself, which usually comes at night to take goats. Leary (2016:109) assert that the majority of academics agree that the fisi (hyena) ceremony is exploitative, and it does not empower the girls who participate in it. Their rights are not protected, and their dignity is not honoured. This practice can be regarded as one part of gender-based violence, and an act eroding human dignity, as mentioned in chapter 5 (section 5.3) of this research.

3.3.2.1. Aims of Sexual Cleansing as Part of Girls' Initiation

The final practice in the genuine girl's initiation rite is sexual cleansing. It is a ritual in which girls who have entered adolescence go through a two-to-four-week initiation process. During this time, they sit under the anamkungwi (female initiators/counsellors), who instruct the initiates about various sexual difficulties now that they are old enough to marry. They are taught to be polite, courteous, and submissive wives, as well as about personal hygiene, sexuality, and womanhood.

Similarly, Waria (2018:299) confirm that the concluding rite is unprotected penetrative sexual intercourse with fisi, when they are expected for the first time to prove their understanding and put into action all they were taught by the initiators about satisfying males as their future spouses. Sexual cleansing is encouraged in order for future marriages to be successful. They are advised to engage in *kudzola mafuta* (smear lotion on the body) or *kusasa fumbi* (remove dust from the body) sexual trial practice. As lotion is not permitted throughout the initiation stage, their skin is said to be dry and dusty. As a result, it is claimed that sexual contact with fisi cleans the initiates.

Unprotected intercourse is recommended since condoms are thought to prevent the man's sperm from thoroughly cleaning the girl. A fisi (typically a considerably older man) is paid by the girls' parents, or acquired by *(anakungwi*, i.e., counsellors or instructors) to have sex with the girl initiates to mark the end of the initiation rite. The fisi is sometimes transported to the location of the initiation. Before the fisi is deployed, the girls are taught *kunyekulira/kudikulira*, which refers to the sexually suggestive wriggling of the waist during sexual intercourse in order to ensure pleasure (Warria, 2018:300).

Peters et al. (2010: 295) attest that the cultural rationale for sexual intercourse at the end of the initiation ceremony is not to cleanse the girl but 'heat' her, bringing her from the cool state of childhood and initiation to the warm state needed as an adult. She is then declared an adult after the sexual symbolic encounter with the fisi, and she is presented to the community. This type of culture is a violation of a person's dignity as discussed in chapter 5. It is also a violation of the sexual rights of the youth where one has the right to choose a sex partner.

3.3.2.2 Effects of Fisi Initiation Ceremony

As much as the traditional custodians may have a clear and good reason to practise the fisi tradition, this cultural practice has disadvantages when it comes to sexual reproductive health among the youth. The fact that young girls are instructed to sleep with old men at a tender age may encourage them to start indulging in sexual intercourse that may result in unwanted pregnancies.

Fisi's unprotected sex puts the girls at risk of sexually transmitted infections because they are exposed to unprotected sexual contact. The *fisi* himself is also at risk of infecting his wife, and other women who may hire him at some point. Leary (2016:123) states that the severe trauma of child sexual abuse and exploitation exists in a culture filled with social messages promoting the sexual objectification of children, implying that children are sex objects for sexual use by adults. Exposing girls to sexual behaviour at a young age may inspire them to continue engaging in sexual intercourse, forcing them into early marriages. Early marriages lead to early school dropouts. After dropping out of school, one will not be monetarily productive enough to contribute to meaningful family growth. Furthermore, if this person is unable to contribute to the country's economy, the levels of poverty per household would rise, producing a vicious cycle of societal poverty.

Notably, the guidelines given to the girls on hygiene, respect, and obedience to their future spouses are good; but it appears that they go too far in training them how to have sex with males. Furthermore, following the real initiation ceremony, they plan a graduation ceremony to celebrate the beginning of the adult stage. During this performance, they sing songs that accompany sex-stimulating dances packed with sexual implication and expletives (Banda & Kunkeyani, 2015:3). This is an insult, a breach of human dignity, and a kind of abuse for the girls, and everyone else involved in the ritual. Human rights activists have called this a sexual

violation of children's rights. The African Children's Charter has sections forbidding harmful cultural behaviours as well as particular phrases that can be invoked either directly or indirectly to advance teenage girls' sexual health rights (Duraboye, 2013:24). The violation of children's rights in the fisi ceremony generates significant areas to explore as we seek to answer the study's research question.

3.4. Chinamwali Sexual Initiation Ceremony

Chinamwali is another type of initiation practised in Malawi, primarily among the Chewa people. The majority of Chewa women are *chinamwali* initiates. In Chewa society, only initiated members of *chinamwali* are considered adults. *Chinamwali* is an essential part of a Chewa woman's life. While praised, *chinamwali* emphasises positive principles such as cleanliness, respect for seniors, and a clothing code for girls. During *chinamwali* sex education, they are also taught behaviours that may have a negative impact on the lives of females (Daka et al., 2020:141).

Girls are introduced to *chinamwali* school after they experience their first menstruation. This is usually between the ages of 10 and 18 as part of a series of puberty initiation rites. *Chinamwali* is an initiation school for girls (Daka et al., 2020:141). Longwe (2003:70) adds that *chinamwali* is a stage of holiness in which the uninitiated are isolated from the 'profane world' and brought into the domain of the ancestors to be trained extensively for five days in *miyambo yamakolo* (ancestral customs). The *anankungwi* (instructors) are supposed to be the keepers of the *miyambo yamakolo* on behalf of the living dead at *chinamwali* (Longwe 2003:70).

A Chewa woman must undergo *chinamwali* to achieve complete female adult status (Daka et al.,2020:142). Sex education is the most important component of *chinamwali* initiation for girls. Longwe (2003: 72) asserts that the objective of *chinamwal*i is sexuality training. The initiates are removed from the profane world and sent in isolation for five days to acquire instructions for their new adult positions. Every initiate, regardless of age, receives this training. The females are teased while they get instructions during the ceremony. The content of their teachings is presented through songs and dances.

The girls are also given practical advice about sex and childbearing. Critics of this practice believe that it influences girls to practise having sex at a young age. This lesson has a higher

likelihood of encouraging the girl child into exploring how best she may practise this, which may eventually lead to promiscuity (Longwe, 2003:72). It may also encourage early marriages, adolescent pregnancies, and sexually transmitted infections. This *chinamwali* initiation ceremony has a harmful impact on a young person's sexual and reproductive health. Like the cleansing initiation ceremony in the *fisi* rite, the *chinamwali* ceremony culminates with the introduction of *fisi*, a chosen man who evaluates the sexual skills of the young girl following the initiation ceremony (Daka et al., 2020:142). This is one of the cultural practices that promotes early marriages and girls are also prompted to have sexual activities even after initiation ceremony before marriage.

3.5 Effects of Chinamwali Initiation

Like any other initiation rituals, *chinamwali* has various effects on the initiates. In most cases, the content of the training the initiates receive prepares them for marriage. These societies show that *chinamwali* prevents girls from making their own independent decisions. I discuss below other effects of the practice.

(a) Early Pregnancies and School dropout

The high prevalence of adolescent pregnancies is linked to some adverse effects of traditional initiation rites for girls known as *chinamwali,* among other things (Daka et al., 2020:144). This is linked to *chinamwali*, because the majority of the principles imparted revolve around sex and marriage. However, their wording in these situations is not often as plain as required. It is rich in metaphors, which are commonly expressed through songs and dance (Munthali & Zulu, 2007: 23; Banda & Kunkeyani, 2015: 12). When discussing sexual reproductive health among young people, adults must be open and honest because the youth are constantly exposed to a variety of sex information platforms. Messages can be incomplete, unclear, or misleading, and young people can misconstrue metaphors like 'playing with guys' (Munthali & Zulu, 2007: 23). This approach to dealing with young people's sexual reproductive health may put their lives at risk of teenage pregnancy. They are even given a *fisi* to practise their sexual abilities. This teaching may motivate the adolescent to want to be sexually active rather than abstain. There is a need to investigate other better ways to modify how these rituals are performed to prevent young people from teen pregnancies.

In addition to underage pregnancies, this promotes early marriages due to the girls' desire to sleep with men after undergoing sexual initiation at the *chinamwali* ceremony. Longwe

(2003:42) argues that this tradition has contributed to polygamous families because some males decided to marry the girl after the ritual rite. It was also recorded as a source of premarital pregnancies among girls in some circumstances since some men keep meeting with the girl surreptitiously. These are some of the consequences for young people's sexual and reproductive health because of being exposed to teachings that are inappropriate for their age.

(b) Sexual Transmitted Infections and HIV/AIDS

Aside from early pregnancies and teen marriages, girls and fisi are both at risk of spreading sexually transmitted infections since they engage in sex without any protection. Furthermore, sex education includes various misunderstandings about menstruation. Contraception methods or the use of condoms are not emphasised as a prominent component of sex education in initiation rites. Moreover, Longwe (2003:42) mentions that while the family is hunting for *fisi*, they look for someone who is HIV/AIDS free, because the elderly women can recognize people who are sick just by looking someone in the eyes. There is an urgent need to re-look into these cultural aspects as they seem to affect the sexual reproductive health of the youth for the rest of their lives.

(c) School Dropouts

Teenage pregnancies and early marriages cause girls to drop out of school. These dropouts begin with absence from school, because most *chinamwali* celebrations last weeks or several days, keeping girls out of school. This absenteeism may negatively affect the way they perform in class, causing the girls to lose interest in school and eventually drop out.

3.6 Jando and Nsondo Initiation Ceremony

Jando and *nsondo* rites of initiation are located in Malawi's southern region, primarily among the Yao people in the districts of Machinga, Mangochi, and Zomba. Jando and *nsondo* are two distinct initiation rituals. Khamalo (2018:14) states that *nsondo* is a customary rite of passage for Yao females aged twelve to fifteen. *Nsondo* initiation is a traditional method in which the community trains girls to become responsible members of the family by introducing them into womanhood. While *Jando* is purely an initiation ceremony for boys aged nine to twelve, the community trains the children as they progress from boy to manhood. Khamalo (2018:16) adds that teaching at *Jando* and *nsondo* is a process of identity formation. The roles and

responsibilities that are taught to boys and girls serve as a tool for the growing youth to identify their place in society. Girls are turned into productive women by being assigned womanhood roles, whereas boys are developed into responsible men. Jando is thought to be associated with Islamic religious practice. Dick (2012:123-124) clarifies that *Jando* is not solely a religious ceremony, as Christians and nonreligious individuals both send their children to Jando.

3.7 Teachings in Jando

The most frequently mentioned positive components of initiation rituals are lessons in good manners and community values. Hygiene and reproductive information are also commonly supplied.

(a) Moral Instructions

Parents take their children to this ceremony in the belief that it is the only way for them to learn Yao cultural values and standards. It is time for the society's chosen elders to advise the initiates about morals, respect for elders, and parental authority. They are also taught their assigned communal roles and about their ancestors' hidden stories, funeral services, and sexual interactions. The majority of the lessons are delivered through songs, and analogies (Kwartleng, 2014:20).

(b) Circumcision and Sexual Rites

Circumcision occurs between the ages of 9 and 12 years of initiation. Custodians of customs claimed that teenagers are circumcised at this age range, because it is the age of the Yao people's rite of passage from childhood to adulthood. Circumcision is performed as a rite of passage (Bengo et al., 2020:37). Similarly, Banda et al. (2014:3) explain that circumcision, or the surgical removal of the foreskin is part of the initiation process for boys. This was done by the 'ngalibas' (instructors), who uses a sharp knife to circumcise all boys under one *tsimba* "initiation shelter."

Boys are considered adults soon after their circumcision. They go through another stage known as kutaya mafuta (spilling/throwing away body lotion). They are supposed to finish this passage by engaging in unprotected sexual encounters. It is believed that this sexual intercourse would protect them from contracting 'tsempho' (an illness characterised by persistent coughing and diarrhoea) if they began playing or sharing food with other children who or whose parents had been sexually active during the time the boys were at the *tsimba* (initiation shelter). Another belief is that if boys do not have sex in this manner, they will later have difficulty sexually

pleasing their spouses and that girls will have difficulty in delivery, become infertile, or become continuously sick if the ceremony is not completed by sexual actions (Banda & Kunkeyani, 2014:3).

When it comes to information transmission on the sexual reproductive health of youth, the practice of involving initiates in sexual intercourse outside marriage under the guise of satisfying some cultural practice becomes a compromise. This is why some people consider such cultural practices to be detrimental. This could have been the ideal arena for advising young people on how to manage their sexual and reproductive health. Furthermore, Jeffrey (2012:8) describes initiation songs as being full of sexual stimulation. While the emphasis for female initiations is on training women to sexually satisfy their husbands, no such teaching occurs in jando. There are only a few rules about sexual concerns, which are mostly addressed through songs.

Kwartleng (2014:18) observes that in addition to the stimulating songs stated above, *Jando* functions, in a variety of ways, as an underlying influence on young boys' sexual behaviour in rural Domasi. Jando is meant to represent the passage from boyhood to manhood. As a result, the rituals themselves include preparation for many aspects of this new life stage, such as the shift to sexual maturity. Throughout the Jando initiation, circumcision is frequently mentioned as a preparation for sexual debut. Furthermore, as opposed to formalised education and conventions, boys learn the intricacies of sexual behaviours through informal discourse with initiation counsellors, and their friends. The impression among the boy initiates is that soon after graduation from the ritual ceremony, they have the right to engage in sexual intercourse.

(c) Hard Work and Endurance

In addition to the stimulating songs quoted above, Kwartleng (2014:18) observes that *Jando* functions as an inherent impact on young boys' sexual behaviour in rural Domasi in a variety of ways. Jando is meant to symbolise the passage from boyhood to manhood. The rituals themselves therefore involve preparation for several aspects of this new life stage, including the shift to sexual maturity. Some songs performed at the Jando initiation ritual promote farming as one of the man-related roles.

Noticeably, farming imagery is featured in these songs. Farming, as an image, refers to any type of labour that requires strength and effort (Khamalo, 2013:19). When these songs are sung,

they help to prepare males for their new roles as they transition from boyhood to manhood. They prepare them to be responsible fathers to their families. In this situation, one may claim that it is the time when gender roles dictate domestic responsibilities. Girls are also taught how to cook, and gather firewood. In other words, boys are also taught to tolerate suffering through the pain of circumcision. The shedding of blood during circumcision is said to tie the new men to the living dead, who are thought to be living on the earth figuratively. These initiates endure anguish as they are forced to stand on one leg for hours until their family pays to redeem them. This ceremony is intended to instil discipline and prepare the boys for the trials and responsibilities that come with being a man. As much as the curriculum's creators perceive it as a better means of preparing boys for future problems, some may see it as a form of torture. This form of torture inflicts pain on one's body.

Christianization of initiation rites.

In the wake of identifying positives from negative aspects of the *chinamwali* practices, some scholars advocated for the Christianization of girls' initiations. It is a matter of isolating what is good, and leaving bad practices. Fiedler (2005:11) notes that efforts have been made to Christianize *chinamwali* by some denominations such as the Catholic, Baptist church, Nkhoma, and Blantyre Synods in central and southern parts of Malawi where the chinamwali initiations are common. There are variations in the Christianization of initiation rites mainly chinamwali. However, the common agenda is that there have been attempts to Christianize chinamwali to perfect, and iron out some of the harmful practices. The good part of this Christianization of initiations managed to remove oppressive practices such as fisi (hyena), and insulting songs (Fiedler, 2005:45). Phiri (1997:35) argues that although the chinamwali ceremony was regarded highly among the Chewa people, no-one questioned the idea of involving the initiates in ritual intercourse as violating their sexuality. Harmful sexual cultural practices like chinamwali definitely put women and girls at risk of HIV/AIDS infection (Phiri, 2003:11). Some of the practices such as fisi (hyena) in the chinamwali were classified as cruel and degraded by the church. Research was conducted to find out which ones were not acceptable during the Christianization of initiations, hence the birth of Chilangizo (Phiri, 1997: 57-58). For instance, the Baptist Church in Malawi in an attempt to Christianize Chinamwali developed the chinamwali church handbook. In this Christianized chinamwali, they teach the initiates good behaviour towards parents, neighbours and elderly people; hygiene, among others (Fiedler, 2005:23). Livingstonia mission, which is the present day CCAP Synod of Livingstonia was however not concerned with this move as there were no clear initiations being

practiced in the north that could have affected Christian practices. The Synod of Livingstonia can also borrow some of these strategies if it wants to deal with SRH of its youth.

3.8. Parents' Silence on Sexual Intercourse and Sexuality

Despite all the sexual initiation rites outlined above, there is still a sense of parental unwillingness to discuss sexual intercourse and sexuality with their children. Instead, kids rely on others, such as their aunts and uncles, to discuss sexual reproductive health issues. Mkandawire's research in Blantyre District, where he questioned traditional authorities, church leaders, parents, and some adolescents, revealed that parents were found to be hesitant to discuss sex and sexual themes with their children (Mkandawire, 2012:67). Similarly, discussing sexual reproductive health with your children is frowned upon. Mkandawire (2012: 67) further notes that it appears many parents continue to struggle to communicate with their children about issues about sex, although such issues are no longer remain in the private domain. Traditionally, when a girl experience menarche, a close relative, or anamkungwi,[2] is called to advise them about how to care of herself, and how to handle herself during menstruation. The girl will be taught not only about hygiene, but also about sexuality and relationships with men in general. Notably, what parents fail to consider is that even if they remain silent, the young will learn this from classmates and various popular media sites. For example, according to the same study, "they only admitted to knowing very little about sexual intercourse and sexuality as their parents did not discuss these with them" (Mkandawire, 2012:69).

Relatedly, the research conducted by Rawson and Liampuhong (2010: 357) found that this culture of parental silence is also evident among the Vietnamese. The young women agreed that there was minimal openness in the traditional society around talking about sex. It was also found that such discourse was frowned upon, and as a result, it was not expressly mentioned at home. One of the interviewees added, "Ohh, we never talked about that stuff (sexual issues at home)." It's not like families in Australia. "Sex is never discussed at home with a Vietnamese family."(Liampuhong, 2010:537).

[2] A woman counsellor to girls who have puberty stage for sexual guidance.

Meanwhile, this culture of silence on sexual reproductive health by parents may put their children at risk since there is no monitoring tool to evaluate whether the anankungwi or an aunt is teaching the right things to their children. All is done out of trust and fulfilling what culture dictates. The belief behind this is that parents who discuss sexual reproductive issues with their children are endorsing and giving them permission to be promiscuous.

3.9. Types of Early Marriages

Early marriages are one of the challenges of lack of SRH that affects the youth. These marriages however occur in different ways depending on the situation and context where it has taken place. The practice of early marriages is found in different forms in Malawi depending on the customary practices of that area. Some of the early practices include *Kusomphora,* (abduction) *Chithulira, ukwati wotulira* (Marriage by default*), kupimbira or kutomera* (debt repayment marriage), *mbirigha* or *Skazi* (bonus wife) (Banda & Kunkeyani, 2014:6). Some of these practices are much more common in the northern ethnic groups of Malawi. In most cases, it is done without the consent of the girl, especially in *skazi* and *kupimbira* customs.

(a) Kupimbira/ Kutomera

Kupimbira or *kupawira* (debt repayment) is very common among the Ngonde people in Karonga District. This practice involves the parents of a girl child who offers her into marriage as a debt payment. The creditor, often an older man, and mostly rich, marries the girl. The disparity between the ages of the man and the girl is inconsequential. Some girls may even be pubescent (Muula, 2015:16). Banda and Kunkeyani (2014:6) further observe that the practice also affects boys, but it is the girls that are most often put as security. Muula (2015:16) also explains a similar practice found in some parts of the southern region in Malawi. This practice is called *Kutomera*. *Kutomera* may involve an elderly man asking to marry a girl of school age. This is done with the permission and encouragement of the girls' parents. In the meantime, as the man or boy waits for the girl to reach marriageable age, the boy or old man is supposed to visit frequently and offer to the girl, implying gender discrimination. This may also contribute to early school dropouts among girls, since they may see no reason to finish their education when a guy is waiting to marry them. Most of the parents of such girls do not encourage them to pursue education, but instead encourage them to dedicate their time to learning gendered household chores.

Nevertheless, the Malawi Human Rights Commission (MHC 2005:23) sees this is discriminatory and violates the rights of girls. Several rights of a girl child are violated,

including the right to an education and the freedom to choose her husband. Mubangizi (2015:161) likewise attests that the concepts of sexual rights are frequently muddled and used interchangeably, although they do not signify the same thing. The fact that these two concepts are anchored in the most fundamental human rights principles, particularly those relating to women's health, is central to them. The World Health Organization has defined sexual rights to include, among others:

1. The right of all persons to the best possible standards of sexual health, including access to SRH services, free of compulsion, discrimination, and violence.
2. Concern for bodily integrity
3. The right to select a mate.
4. The right to decide whether to engage in sexual activity.
5. Sexual encounters that are mutually agreed upon.
6. Consensual marriage.

These early marriage practices that conflict with some of the above-mentioned rights violate the rights of the girls. Civic education on the effects of such marriages is crucial and can target traditional leaders and elders who are custodians of such cultures.

(b) Kutsomphora or Kusomphora

Kutsomphora, or *kusomphora* (abduction, or elopement). The practice is when the boy decides to visit the home of girls at night and take her to the boy's home. In most cases, this is done without the knowledge of the parents of either side. Later, the boy's parents may send someone to inform the girl's family that they should not worry about the whereabouts of their daughter because she is with them. This messenger usually carries a gift of a chicken to the home of the girl as a symbol of apology for the act of abduction. Thereafter, the girl's parents charge the dowry (*lobola*) according to customs put in place in that society. Therefore, this marks the beginning of the early marriage. This happens to underage girls if the parents have given consent. Banda and Kunkeyani (2014:6) reiterate that *kusomphora* is like a culture in South Africa called *Ukutwala* (kidnapping) for marriage in which a man may abduct a girl and sell or force her into marriage.

(c) Chithulira or Ukwati Wotulira

Chithulira[3] or *ukwati wotulira* (marriage by default) is a common practice among the Tumbuka people (my tribe) in the northern part of Malawi. It happens when a boy impregnates a girl out of wedlock, or a schoolgirl. To avoid shame, embarrassment, or out of anger, the girl's parents ask an elderly woman known as (Ntchembere[4]) to find out from her about the one who is responsible. Once the girl discloses the one responsible, she is escorted to the boy's home and that marks the beginning of the marriage hence the name *chithulira* (forced marriage) or marriage by default. In most cases, some boys refuse the responsibility, and do not marry the girl. This is a huge embarrassment for both the girl and her parents, and some young women who cannot condone such act usually commit suicide. WHO (2013: 24) agrees that exposure to traumatic sexual encounters can cause stress, fear, and isolation, which can lead to depression and suicidal behaviour. Furthermore, a girl or her parents may choose an unsafe or induced abortion. Similarly, WHO (2013: 23) maintains that the unplanned pregnancy that warrants an induced abortion may result from sexual assault and coercion, or from an incapacity to negotiate the use of a condom due to fear of violence. As the journey culminates in a crisis, this practice may hurt the general sexual reproductive health of the youth.

(d) Mbirigha or Skazi (Bonus wife)

The giving of a m*birigha* or S*kazi*[5] (a bonus wife) to a beloved son-in-law is another practice that is a typical example of child marriages or forced marriage. This is very common among the Tumbuka and Ngoni tribe in the northern Malawi. The practice takes place when the son-in-law of the family has been loved so much by the family of a wife, or he is rich. As a way of appreciating the role the son-in-law has assumed in this family, the wife's family gives him the younger sister of their daughter as a second wife. He does not need to pay any lobola (dowry). In most cases, this happens when the son-in-law is a well-to-do person.

3.10 National Policies on Harmful Cultural Practices

This section addresses and analyses some of the hazardous cultural behaviours that have been denounced in the wake of the spread of HIV and AIDS. They may also be damaging to the general sexual reproductive health of the youth, which is the main topic of this thesis. The concept of harmful traditional practices emerged in UN circles as early as the 1950s. The

[3] This is Tumbuka language while wotulira is Chewa language.

[4] An elderly woman in the village who can give counselling to girls In Chichewa, she is called anankungwi.

[5] Mbirigha and Skazi mean the same thing only that mbirigha is in Tumbuka language while Skazi is in Ngoni language.

General Assembly passed resolutions such as one referring to "customs, ancient laws, and practices relating to marriage and family considered inconsistent with the principles set out in the Universal Declaration of Human Rights in 1954". (Longman et al., 2015:2). The resolution called on all states to abolish such customs, laws, and practices by ensuring complete freedom in the choice of a spouse; abolishing the practice of bride price thus guaranteeing the right of widows to the custody of their children and their freedom to marriage of their choice; eliminating child marriages and the betrothal of young girls before the age of puberty, and establishing appropriate penalties where necessary (Longman et al., 2015:1).

Similarly, Article 1 of the African Charter on the Rights and Welfare of the Child maintains the concept of a legal duty on States to prohibit "any custom, tradition, cultural, or religious practice that is inconsistent" with the Charter (Article 1(3) of the Charter). Article 21 goes beyond this commitment by encouraging and forcing states to remove detrimental social and cultural practices impacting the welfare, dignity, normal growth, and development of children. These are habits and practices that have a negative impact on a child's health or life, as well as practices that are discriminatory based on gender, or other status (Gose, 2002:51-52).

The General Assembly resolutions and the mandates of the African Child Charter, the Malawi government has declared certain cultural practices to be harmful, discriminatory, and in violation of human rights. As a result, several rules were enacted to prevent some of these cultural behaviours. Some cultural practices in the context of HIV/AIDS have been discovered and explored in this debate. This paragraph therefore outlines the policies and legislation put in place to combat these behaviours. The Malawi's national HIV/AIDS policy indicates that many customary practices enhance the risk of HIV infection. Among these are polygamy, extramarital sexual relations, traditional practices such as widow-widower inheritance (*chokolo*), death cleansing k*upita kufa*), forced sex for young girls, coming of age (fisi), circumcision (*jando* or mdulidwe) (GoM, 2003:21). To stop these harmful practices, the Malawi Government has done the following.

1. Educate traditional leaders and their subjects about the hazards of customary behaviours such as forced sex for young girls, coming of age (fisi or kuchotsa fumbi), and others, in collaboration with civil society, especially religious leaders.

2. Ensure that traditional leaders halt or modify harmful customary activities to make them safer and prevent HIV/Aids transmission or promote alternative customary practices that do not put individuals at risk of HIV infection.

In addition to the foregoing measures, Malawi established a special law commission in 2006 to draft new HIV/AIDS legislation. A report titled "Report of the Law Commission on the Development of HIV/AIDS Legislation" was issued in 2008. The report states that:

> "At the general assembly in June 2001, Heads of Government agreed that strong leadership at all levels of society is essential for an effective response to the epidemic: leadership by governments in combating HIV/AIDS is essential and their effort should be complemented by the full and active participation of civil society, the business community, and the private sector; and that leadership involves personal commitment and concrete actions" (Page, 2019:69).

Although all the aforementioned laws and policies are in place to help prevent the spread of HIV/AIDS, they are also attempting to enhance the sexual reproductive health of the youth. Not only will the policies minimise the spread of HIV/AIDS, but they will also cut early marriages and teen pregnancies. The law commission also recognized that the need to ameliorate or halt damaging cultural behaviours necessitates communal responsibility, implying that all religious leaders, the private sector, and the business community must participate. It is therefore in the best interests of our research to involve the church in discussions about SRH among teenagers. Section 24 of the Malawi legislation required the state to establish laws to abolish customs and practices that discriminate against women and girls to safeguard women and girls, and this legislation was passed in 2010. The National Aids policy criminalises customs and actions that increase the risk of HIV infection. The commission had proposed that anyone who subjected another person to detrimental cultural practices be charged with an offence and sentenced to a fine of K100,000 Malawian kwacha (i.e., $150), and five years in prison. The "first schedule" lists so-called hazardous practices. These are among others:

1. Chimwanamaye (wife swapping): Two different people may agree to swap their wives or husbands just to have another feeling of a friend's partner. It is done under the mutual agreement of both parties without any payment. This is mainly done between good family friends.
2. Fisi kusasa fumbi (forced sex for young girls, coming of age)

3. Kupimbira (young girls are given in marriage to wealthy old men as payment for their debts or other purposes) (Page, 2019: 72).

According to the Law Commission (2008:33), some cultural and religious practices make women and girls more vulnerable to HIV/AIDS. The commission also echoes that such actions not only offend the dignity of women but do so regardless of their gender or marital status. The panel highlights that, while the freedom to engage in a culture of choice is protected by the Constitution in most situations, women participate in cultural traditions without free permission due to their high reliance on men as wives, mistresses, and children. The panel also states that, in addition to worsening the spread of HIV/AIDS, these detrimental cultural practices violate and demean women's rights. In conclusion, the commission mentions that these practices are discriminatory against women.

These laws and rules demonstrate how some cultural traditions violate the rights and dignity of youth. Furthermore, some of these rituals expose girls to premarital sex exercise, endangering their SRH. This exposure is also to detrimental rituals may have an impact on their psychological and emotional lives since they induce trauma, particularly when forced to have sex with men.

3.11 Conclusion

This chapter focused on some of the common sexual cultural initiation rites that are common in Africa with an emphasis on Malawi. The aim was to investigate how some cultural practices affect the SRH of the youth. The discussion further analysed the main teachings of these initiations. It has been observed that these initiation rites intend to educate the youth on morality and good manners, how to respect parents, and elders and grow up as hard workers. It was further noted that during initiation ceremonies, young people were also trained how to practise sexual intercourse, yet they were not married. That could be concluded as one way of exposing young people to have an early involvement in sexual practices. This may affect their SRH life as well.

The chapter also presented how these initiations affect the SRH of young people. Several practices were identified as damaging by human rights charters during the discussion. The practices were identified as a violation of women's and girls' human rights. Jando, chinamwali, cleaning initiation, nsondo, and the silent culture are among the initiations described. The study

also looked at different sorts of early marriages and their consequences on teenage sexual well-being. Kusomphora, chithulira, kupimbira, and kutomera mbirigha were among the early marriages described. Some of these marriages were found to have a significant impact on young people's SRH since such people were coerced into marriage at a young age. This means they will begin having children while they are not economically enabled, resulting in the formation of a poverty cycle. Considering these findings, the purpose of this study is to investigate how the church may intervene and promote sexual reproductive health among adolescents in the CCAP Synod of Livingstonia. The next chapter analyses how theology or religion affects young people's SRH.

CHAPTER 4

SEXUAL REPRODUCTIVE HEALTH AND RELIGIOUS BELIEFS

4.1 Introduction

This chapter investigates, debates, and critically examines religious perspectives toward SRH among young people. Religious beliefs and practices are frequently considered as potential gatekeepers of sexual attitudes and actions. Religion tends to separate human sexuality by emphasising a dualistic division between body and spirit, according to historians, and anthropologists dating back to the 5th century BC. While modern religion has endeavoured to emphasise the link between spirituality and sexual expression, there has historically been a desire to regulate sexual expression, especially outside of marriage. Understanding religion's function in controlling sexual behaviour is difficult and has far-reaching consequences (Murray et al., 2007:222). This chapter further seeks to address a central concern of realising sexual reproductive health and rights (SRHR) through policies and programs and the relationship between religious norms on sexual reproductive health.

This chapter explores how Christianity respond to the need for SRH among young people in greater detail. Several studies have revealed that most major religions around the world, including Islam, Christianity, Hinduism, Buddhism, and Judaism, prohibit or promote abstinence amongst young people until they marry (Hamid et al., 2020: 27). These faiths not only promote abstinence, but also prohibit unmarried young people access to contraception (Hamid et al., 2020:27). It also addresses how the church in Malawi directly affects young people's SRH. The focus of this conversation is on the problems, and how the church is implementing government policy on SRH among young people. This will be preceded by a discussion of how the CCAP Synod of Livingstonia is specifically dealing with issues of sexual reproductive health of young people, as the research focuses on the Synod of Livingstonia. Furthermore, the chapter likewise critically examines how the Synod of Livingstonia is implementing the Synod's sexual reproductive health rights (SRHR) policy, which was enacted in 2017.

The chapter further provides a survey of theoretical and theological ideas about sex and SRH issues in general, as well as among young people in particular. It also investigates whether

religious ideals such as abstinence, and no sex outside marriage correspond to reality on the ground, and how these values influence public sexual reproductive health policies. Finally, the chapter studies religion's involvement in SRH, its effects, their attitudes toward sexual reproductive issues, and the church's likely role and position on SRH.

Since the discussions focus on how Christian religion perceive sex, and SHR, it will also look into Christian denominations' reactions to the precursors of sexual reproductive issues such as pregnancies, early marriages, and infections that are sexually transmitted. Similarly, the tension between practised theology, and experienced reality among young people, the church, and the public health system are also highlighted in this chapter. Finally, the chapter investigates how Christian religious denominations' values might be critically incorporated into public sexual reproductive health policy. Likewise, an attempt to highlight key trends and areas of contention concerning religious elements of reproductive health is made in this chapter. This discussion is far from exhaustive but rather highlights current dimensions of interest in line with the topic of this research breaking the silence of SHR.

4.2. Religious Attitude on Sexual Reproductive Health among Young People

Religion is a key component in many people's social networks, where religious rules govern learning and growth. To comprehend religious rules, we must first define the term religion. Several scholars have attempted to precisely define religion in the following ways. Religion is defined by Liquis et al. (2012:602) as "the idea of beliefs and practices that are grounded in the conviction that there is a transcended (nonphysical) dimension of life." Furthermore, religiosity emphasises what are considered private religious behaviours, such as viewing religious television regularly, reading the Bible or other religious literature, or saying grace before meals. According to Cotton et al. (2006: 473), religiosity can be defined as the formal institutional and visible manifestation of the sacred, and it can be measured by variables such as religious importance, belief in God, frequency of religious service attendance, frequency of prayer, and frequency of meditation.

Furthermore, Bekwith and Morrow 2005: 361) define religiosity as a construct encompassing religious identity, actions, attitudes, and perceptions to identify the impact of religion on health behaviors. Edwards et al. (2008: 448) mention that religion is a collection of institutionalized beliefs in a higher power that contains legislation or regulations for how to live one's life.

Tseung-Hao (2011:26) defines religion as a system of intersubjective ideas about the ultimate meaning that believers hold sacrosanct.

Tseung-Hao (2011:27) further explained three reasons why people follow religious norms, and these reasons are presented below.

1. Actors may adhere to religious norms because of reward and punishment incentives, whether those incentives are considered to apply to the individual or some broader social unit. Residents of Saudi Arabia, for example, face the threat of arrest and corporal punishment from religious police known as Mutaween if they violate strict Sharia rules governing activities such as fraternisation between men and women, proper dress codes, shop closures during prayer times, and serving alcohol, among others. In Genesis, for example, God punishes Adam and Eve for disobedience by evicting them from the Garden of Eden.
2. Second, actors may adhere to religious norms out of a shared sense of identity. Attending religious services, repeating specific prayers, or simply participating in religious community activities. All these things reflect and maintain a feeling of communal identity. Religious conventions and fundamental beliefs bind religious communities. Following these principles (regardless of one's conviction) contributes to a stronger feeling of communal identity. Transgressing them, on the other hand, can put one outside the group, and a large-scale challenge to a religious norm can divide the community and lead to division. This topic is critical in this study because it examines how different groups or religions manage the subject of sexual reproductive health; some are liberal, while others are quite conservative especially on the issue of providing safe sex education to teenagers. This issue is further discussed in the succeeding paragraphs of this study.
3. People may follow religious standards because they believe, subjectively, that the underlying religious ideas constitute a true link to the sacred and hence a reflection of the ultimate authority. This conviction stems from an individual's reverence and awe of the mystery that it represents. We can refer to it as faith.

It is important now to have an idea of why people of the same religion, some are conservative, while some are liberal[6] to the teachings of a particular belief. It may be because of the three

[6] Liberal in other words not to legalistic to the teaching of religious beliefs.

reasons mentioned above. This may also have a bearing on how people behave when it comes to observing religious norms regarding sexual reproductive health among young people.

All these different scholars have defined religious beliefs in different ways, however, what is common in all the different definitions is identity and belief in a set of values. These values have an influence in one's life's style and behaviour. Examining the above definitions, it could be deduced that they focus on values, identity, and their religious practices as a way of expressing their inner belief. One of the many religious values, among others, in line with the topic of this study is how religious beliefs perceive sex, and sexual health of young people. The way religious beliefs perceive SRH largely determines how religious people handle sexual reproductive health related practices among the young people.

Several studies have been undertaken in various contexts concerning religion, sex, and sexual health, whether in general or particularly for young people. This research has indicated that religious views may be seen as incompatible with public sexual health policy. At the 1994 Cairo International Conference on Population and Development (ICPD), reproductive health was defined as a "state of complete, physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system, and to its functions and processes." (WHO, 2017:1).

As mutual as they are, family planning, maternal and newborn health care, prevention, diagnosis, and treatment of sexually transmitted infections (STI), including HIV; adolescent SRH; cervical cancer screening; and infertility management and prevention are all part of SRH. These services aim to prevent poor SRH, such as pregnancy and childbirth problems, unwanted pregnancies, unsafe abortion, STI complications, sex assault, and women dying from preventable cancer (WHO, 2017:1). It is crucial to emphasize that the idea of sexual reproductive health has grown to provide a comprehensive and integrated approach to sex and reproduction health requirements. As a result, sexual reproductive health is an interdisciplinary notion that includes a religious/theological perspective. We must also recognize that sexual reproductive health is a public health issue, a human rights issue, and critical to achieving the Sustainable Development Goals (SDGs).

In Metusela et al.'s (2017:836) view, sexual reproductive health is a critical component of life equality, comprising physical, emotional, mental, and social well-being as well as joyful experiences with sexuality free of oppression, prejudice, or violence. This encompasses the

right to sexual health education and information, the right to equality and non-discrimination, the right to choose the number and spacing of one's children, and the freedom to feel and express sexual desire. Traditional religious institutions, such as the church, have preached that sexual intercourse should take place between a man and a woman within the context of marriage as part of moral instruction. As a result, young individuals should refrain from engaging in premarital sex until they marry. Religion and sexuality are inextricably intertwined in that religion can impact a variety of sex-related decisions such as abstinence, birth control, and abortion. Furthermore, religious belief, and practice are related with less permissive views toward extramarital sex and, as a result, lower rates of non-marital adolescent sexual activity (Crawford et al., 2011:166).

In the United States of America, for example, catholic medical centers and clinicians are bound by ethical and religious directives for catholic health care services, which prohibit prevalent reproductive health care services such as abortion, contraception, sterilization, and assisted reproductive treatment. Each diocese's bishop is responsible for ensuring that catholic hospital ethics committees comprehend the church's moral teachings, and understand how to apply them in daily healthcare practice. Catholic health care organizations are not permitted to participate in actions that are essentially evil, such as abortion, euthanasia, assisted suicide, or direct sterilization (Stulberg et al., 2016:1).

Furthermore, Jayne et al. (2020: 527) state that religious groups, and churches are frequently perceived as having stigma and hostility toward sex and religious teachings about sex and sexual health. Religious organizations frequently emphasize religious principles over facts. Similarly, Mulya (2018: 54) argues that earlier research with young Indonesian Muslims found a close relationship between religion and the mainstream discourse of sexual morality, namely how sex outside of marriage is positioned as immoral and associated with sinfulness. In fact, one girl who participated in Mulya's (2018: 59) research in Indonesia characterised herself as growing up in a devout Christian protestant home. She had been active in her church, and read numerous Christian books since childhood. It was only until when she went to university that she began to doubt her religion, and eventually declared she no longer believed in God. She stated that sex is a biological requirement not a sin.

The concept of sin was based on the idea that God will punish humans if they do something wrong, thus humans will stop doing wrong when they are terrified of punishment. Will people

still do the right thing if there is no hell? The argument here is that sex is a biological necessity that should be tolerated because some people can restrict themselves while others cannot. So, how can religion help people like this who cannot stop having premarital affairs? As a result, there is an urgent need to re-engage in an interdisciplinary dialogue between religious denominations, and sex and sexual health public policy. The reality that some religious views place a high importance on abstinence, and no sexual intercourse outside of marriage, with little or no additional information provided other than dread of undesired pregnancy, sin against God, and eventual punishment should be addressed. 1Corintians 6:18b states that "Every sin, whatever a person commits, is outside the body, but the sexually immoral person sins against his own body".

The above quote may be interpreted as denying minors the opportunity to acquire sexual health education and information, as well as the right to feel and express sexual desire, as stated above. However, universal access to sexual and reproductive health (SRH) is a fundamental human right that is critical to attaining the 2030 Agenda, as stressed in the SDGs relating to good health and wellbeing and gender equality. In a humanitarian setting, the necessity to address (SRH) of young people is extremely critical (Tirado et al., 2020:2). Furthermore, young people aged 10 to 24 years are at the heart of sustainable development, and they both serve as agents of change working to achieve healthy, inclusive, and stable societies; and as those most affected by the effects of climate change, gender equality, sexual abuse, poverty, conflict, and migration (Tirado, 2020:2).

Socialisation for religious reasons in general may have a harmful impact on sex, and sexual health. Such outcomes could include riskier sexual habits and ignorance, which could lead to an unintentional teenage pregnancy, and harm. This could be more significant, because early sexual engagement in adolescence has been recognized as a key risk factor for a variety of unfavourable reproductive health outcomes, including early childbirth and the consequences for maternal and child health outcomes. In addition, there has been a rise in sexually transmitted diseases (STIs), including the human immunodeficiency virus (HIV) (Crawford et al., 2011:166). It has also been observed that choosing to be sexually abstinent may be one of the most difficult issues confronting young people, given the broad exposure to sexually explicit literature that celebrates dangerous sexual conduct, including many sexual partnerships. They may also face psychological difficulties as they attempt to conceal their sexual fantasies to conform to their abstinence belief. Similarly, Efrati (2019:144) affirms that teenagers conceal

sexually relevant thoughts more frequently than their secular counterparts, and that this suppression of cognition is associated with increased compulsive sexual behaviour and lower wellbeing.

One strategy for controlling undesired negative thoughts is thought suppression. Efrati (2019:144) argues that these religious kids may find this compulsive sexual activity and fantasising unpleasant because it contradicts their religious principles. Young people have easy access to sexual knowledge through various media venues, both print and electronic. Furthermore, the disintegration of conventional value systems that define acceptable sexual behaviour among young people implies that adolescence must deal with contradicting values, and less sexuality rules (Crawford et al., 2011: 166). As a result, religious groups may reevaluate how they relate sex, sexuality, and sexual health to their theological principles.

Although religious teachings may be perceived as having a negative attitude toward sex, and sexual health, when we look at religious structures, and networks for the individuals they serve; the opposite is true. Integration of positive health perspectives on sex, and sexual health may promote improved attitudes and results (Jayne et al., 2020:527). It should be noted that some religious communities are also capable of providing education for families and community members into which we might add sexual health syllabus (Puffer et al., 2016: 518). In fact, religion can operate as a mediator and give coping methods for sex-related stress and anxiety. What is needed is to explore the strength and opportunities religion must address, ad cover some gaps already created by religious values.

4.3. Overview of Christian Response to Sex, and Sexual Reproductive Health

The passage discussed above showed how religious beliefs perceive sex and sexual health of young people in general. This further investigates how Religion respond to some of the sexual reproductive health demands among the youth such as safe abortions, teen pregnancies, contraceptives. In other words, the study focuses on how much religious people subscribe to sex and sexual health public policy.

Christianity

The Christian churches' silence on the origin and meaning of human sexuality may have left young people at the mercy of their own burgeoning sexuality and dominant secular societal attitudes and conceptions of sexuality (Crawford et al., 2011:176). According to research

carried out in some Christian churches in South Africa in the context of HIV/AIDS prevention as part of addressing sexual reproductive health among adolescents, the church's leadership avoids openly debating matters of sexuality with unmarried young people. The reason for this is that the norm in many Christian denominations is that the sex border is marriage, and this moral reasoning is prevalent in HIV-prevention teachings to young people. Another significant hurdle to Christian churches fully engaging in HIV prevention is the association of premarital sex with sin. Religious leaders consequently avoid discussing sexuality openly with young unmarried people (Erikson et al, 2010:104). The study also discovered that sexuality teachings were rarely mentioned on the pulpit. The key message to young people was to avoid premarital sex, and to live a healthy lifestyle. For some religious leaders, the only acceptable messages were abstinence based on biblical principles and commitment to one spouse.

As condom use is controversial, the name condom was avoided in most of these churches. This study also discovered ambivalence or split among Christian church leaders over the use of condoms among unmarried individuals to prevent HIV/AIDS. Some leaders agreed to give contraceptives to young individuals they knew were sexually active, either individually or in groups. Others argued that providing condoms to unmarried young people may encourage sinful behaviour among the adolescents (Eriksson et al., 2010:108). According to the findings, parents were judged to be more accountable than religious leaders for informing young people about HIV prevention (Eriksson et al., 2010:109). While they advised parents to discuss HIV prevention strategies with their children, they also recognized a taboo that is typical in most African cultures, as detailed in Chapter 3. Parents are not permitted to discuss sexuality directly with their children. Koch et al., (2019:1) echo that individuals often overlook the topic of sexual activity in a related study done in South Africa. They therefore fail to always provide appropriate information and guidance to girls regarding acceptable sexual attitudes, and behaviour. Adults also warn girls about the bad repercussions of having sex, so they associate having sex with fear of what might happen as a result. Furthermore, Koch et al. (2019:1) observe that when girls ask questions about sex or express their sexual impulses and the need to explore their sexuality, adults frequently respond with anger, which may elicit emotions of guilt and shame and leave them confused and defenceless.

As in many other nations, family life educators, and the church in Jamaica frequently emphasise the value of postponing sexual activity until marriage. However, there is criticism that the church has been deafeningly silent on matters affecting youth sexuality, and it has

failed to address the reproductive health needs of its congregation's youth. Based on that, many young individuals in the church have become sexually active, and participated in dangerous sexual activities (Crawford et al., 2011:165). In the same study, many of the youth respondents indicated a need for their religious denomination's leaders to engage in discussion about the reality of sexual reproductive health issues, as their church's silence limits the scope of transparent lifestyle among Christian-related youths. For example, some young people said, "they were tempted to get involved sexually, but their fear of discussing sexual issues with church members (because they didn't want to be judged) caused confusion and tension, so they succumbed to temptation." (Crawford et al., 2011:166).

The above suggests that allowing youth to articulate their sexual experiences would aid the church in addressing sexual reproductive health issues. In Jamaica, the only method the church resolves concern of pregnancy outside of marriage is to rebuke and ostracise the pregnant woman, effectively suspending her from church activities. Furthermore, the 'sinful' youth, and her parents were denied the privilege of participating in church, such as not giving testimony, preaching, teaching, or ushering (Crawford et al., 2011: 168). This is similar to the Muslim community, which uses (sharia) law to penalise those who become pregnant outside of marriage.

Similarly, in the United States of America, Catholic health care institutions, and clinicians are bound by ethical and religious directives for catholic health care services, which prohibit common reproductive health care services such as abortion, contraception, sterilisation, and assisted reproductive treatment. The directives are implemented by each diocese's bishop, who is in charge of ensuring that catholic hospital ethics committees understand the church's moral teachings and know how to apply them in daily health care practice. Catholic health care organizations are not also permitted to engage in immediate material collaboration in actions that are fundamentally evil, such as abortion, euthanasia, assisted suicide, and direct sterilization (Stulberg et al., 2016:1). Meanwhile, findings from a study conducted among Catholic Priests and Nuns in Timor-Leste, a small country in Asia, showed a divide on the usage of condoms as a means of avoiding HIV-infection as well as a contraceptive strategy among young people. According to Richard (2015: 349), church representatives displayed a range of attitudes and beliefs, some of which appear to contradict official Catholic doctrine and others that appear to support it. Many of them opposed the use of condoms because it would encourage society to participate in free sex, thus fostering promiscuity. Again, Richard

(2015:350) states that the term "free sex" was used by multiple participants from all groups to condemn promiscuous sex.

In contrast, a minority of respondents disagreed with the official Catholic dogma of not using condoms or any other artificial contraceptive method or methods of HIV/AIDS prevention. They contended that, if the church does not discuss condoms as a tool that can protect health, we are denying people access to information and its people's right to have all the information available, as well as information about abstinence (Richard, 2015: 350).
Agha et al., (2006:551) also mention that in Zambia, churches such as the Seventh-day Adventist restrict premarital sex in the church, and anyone found guilty of having premarital sex have their membership revoked immediately. Anyone discovered to be pregnant outside of marriage is kicked out of the church. Those who have been deregistered are not permitted to participate in any religious activities, including receiving holy communion. Relatedly, Agha et al., (2006:551) cite Jehovah's Witness as another denomination that punishes its members for having premarital sex. Members who engage in premarital sex risk being removed from the congregation's membership. This is followed by a public announcement of their expulsion. Premarital sex is forbidden among Jehovah's Witnesses, and the use of contraception outside of marriage is strictly discouraged. Premarital sex is condemned by the most, if not all Christian denominations in Zambia. The strength of the prescription against premarital sex, on the other hand, varies by group's exercise of control over young people's sexual behaviour. Jehovah's Witnesses and Seventh-day Adventists are therefore two religious groups that have a particularly powerful impact over young people in their congregations. In ways that are likely to influence sexual initiation, both differ from other Christian denominations (Agha et al., 2006:551). This diversity in approaches to sexual reproductive health is what makes it difficult for churches to speak with one voice on SHR issues.

For the church to be relevant, it must be in touch with the needs, and reality of young people, and sexuality is one area where young people are screaming out for help. Crawford et al. (2011:176) propose that the church should foster an environment in which young people can discuss their sexuality and acceptable sexual behaviour. The majority of studies on adolescent sexual behaviour suggest that the years of adolescence and the transition to adulthood are related with increases in risky conduct, unsafe sexual behaviour, drug, and alcohol delinquency. In this example, how does Christian faith manage sexual reproductive health among youth in accordance with their religious norms?

Kamara (1999:131) observes that to study options for how the church may handle sexual reproductive health, the church must address the conditions of those being evangelised. Much of the social and spiritual work done by church organisations is amazing, but the church has mostly served as a spectator and commentator on adolescents' reproductive health abilities. In other cases, the church has had a role in preventing teens from accessing reproductive health treatments. Kamara (1999:131) state further that individuals are more than "the saved" and "the lost." As a result of this simplicity, the church has failed to recognize its position in a complex social-cultural setting. The church also makes no attempt to provide support or ethical recommendations to people who are unable to adhere to stringent Christian principles. The church, for example, expressly forbids the use of condoms by adolescents, but Kamara (1999:132) believes that it would be an ethical Christian expression if the church taught unmarried young people who are unable to refrain from sex how to use condoms. Instead, the church appears to be pursuing the easy route of establishing rigorous moral standards and condemning everyone who fails to satisfy them in the strictest sense. The church might take the initiative in bringing the reality of youth sexuality into the public eye, and onto the political agenda. It should take positive action by establishing a youth pastoral ministry to address teenagers' reproductive health concerns. While Kamara (1999:132) recognizes that the church should not dumb down Christian doctrine, if sexual abstinence is difficult to maintain, other ethical principles may be developed rather than rejecting individuals who cannot abstain, and in turn considered as lost souls.

Magezi (2016:2) argues that Christianity often advocates abstinence rather than condom use, which is at odds with reality. When adolescents and youngsters therefore become sexually active, they are more likely to contract HIV, and become pregnant. Given that the church is a subsystem of society, but also a separate organisation, might there be constructive involvement and integration of church and society in addressing adolescents and youth sexual reproductive health (AYSRH) issues?

Magezi (2016: 2) proposes a practical theological response of the church, and its distinctive principles while also realistically reacting to the realities of the needs of adolescents, and youth. In such a paradigm, an engagement that preserves the sacredness of the church while also observing the church's public duty as a communal institution is maintained. However, the church's involvement in addressing communal issues such as adolescent sexual reproductive

health is widely accepted. In South Africa, the fourth priority (pillar) of the national Adolescent SRH, and rights framework strategy (2014-2019) calls for the strengthening and scaling up of community networks focused on assisting teenagers. The strategy encourages parents and faith-based organisations (FBOs) to participate in addressing adolescents' SRH matters by empowering them on sexual issues (Magezi, 2016:2).

The church should therefore bridge the gap between the it, and society, as well as the community split, where churches are often mute on teenage and adolescent sexual issues. Observably, churches are stuck in a bind, because they must defend biblical and moral teaching and principles of abstinence while also responding to the realities of young people who engage in sex (Magezi, 2016:3),

4.4 Church, Sex, Sexual Reproductive Health for Young People in Malawi

Malawi is mostly a Christian country as Muslims constitute 13% of the population. With 21% of Malawians identifying as Catholics, 65% belong to other Christian denominations. In Malawi, Muslims, on average, have greater fertility rates than the non-Muslims= with a total fertility rate of 7.0, compared to 5.3 for Catholics, and 5.6 for other Christians. Contraception use appears to be lower among the Muslims (32% vs. 48%). Overall, 42% of married women aged 15-49 use contemporary contraception, with injectables (26%), and female sterilisation (10%) being the most used methods. Some Malawians receive their contraceptive method at a facility managed by Christian Health Association of Malawi (CHAM), compared to 74% of women receiving a method from a public facility, and 17% from private facilities (National Statistics Office-NSO, and Malawi Demographic Health Survey-MDHS, 2010:23).

Many countries, including Malawi, have been interested in young people's sexual conduct. Adolescents in Malawi encounter numerous problems when it comes to SRH. The National Statistics Office, and Malawi Demographic Health Survey Survey 2015-2016 reported that approximately 13% of girls, and 22% of boys in Malawi began having sexual relations before the age of 15. According to NSO, and MDHS (2015-2016), this has resulted in 29% of adolescent girls becoming pregnant. The findings also established that teenager in Malawi had high fertility, and a high rate of pregnancy. In a recent study, the overall adolescent fertility rate was 20%, implying that one in every five female adolescents aged 15 to 19 years had already given birth. When compared to other African countries, the teenage fertility rate in

Malawi is higher than the rates documented for Kenya (18.5%), Uganda (19.2%), Tanzania (19.6%), and Ghana (10.2%).

Relatedly, Palamuleni (2017 15) highlight that the high rates of adolescent fertility in Malawi could be related to prevalent demographic, and socio-cultural circumstances such as marriage age, age of first sexual intercourse, and usage of family planning. Mgawadele et al., (2017:) also add that adolescent pregnancies relate to poor outcomes such as induced abortions, stillbirths, school dropout, and maternal mortality. Another study conducted by Global Information and Education on HIV and Aids found that young individuals, especially adolescents, account for one-third of all new infections in Malawi (Global Information and Education on HIV/Aids, 2017). Eighty-four percent of people in Malawi live in rural areas. The NSO's report revealed that as at the time of the report, 83% of girls, and 84.1% of boys were living in rural areas of Malawi where, at times, access to sexual reproductive health services is difficult (NSO & MHC, 2018). What we do not know in these statistics is how many Christians and non-Christians are involved in this premarital sexual intercourse considering that most Christian churches prohibit premarital sex.

4.4.1 Challenges to Promote Sexual Reproductive Health of the Youth

Gama (2009: 54) opines that the socialisation of young people in Malawi is informed by Western culture through schools, religion, and other Western media, as well as traditional cultural practices through initiation rites and other traditional institutions. Adolescents acquire ambiguous sexual culture, which can affect their sexual behaviours. Some western sexual message of permitting premarital sex, and some traditional teachings of no premarital sex is irreconcilable. Due to the community's criticism of western notions of SRH promotion, societies may be unwilling to accept modern health promotion.

Furthermore, confusing, and contradictory traditional messages that say no to premarital sex, combined with other traditions such as initiation ceremonies that encourage sexual engagement within a culture, might confound adolescents in their SRH decision-making. The ambiguity and contradictions in sexual culture can thereby make it difficult to develop a successful health promotion campaign since they are perplexing to adolescents' behaviours, in addition to a lack of support for some programmes (Gama, 2009: 55).

To fight against these early marriages, teen pregnancy, school dropout, induced abortions, spread of HIV and STIs, Malawi government is therefore calling upon all stakeholders including faith community the church. The church however has a belief that the foundation of human society is anchored on religion (Olusola & Jegede, 2014:91). Religious communities' response to sexual reproductive health policies raises some questions on the use of condoms, contraceptives, safe abortion to young unmarried people. Many religious communities have strong reservations on universal access to contraceptive services to unmarried young people, which is a pure scientific method adopted by sexual reproductive health public policy. From the perspective of religion infertility, premarital sex, use of condom, advocating for safe abortion is sin (Olusola & Jegede, 2014:91).

This religious perspective has put the church in a dilemma on how to maintain its biblical moral teachings to youth at the same time the government asks the church to promote universal sexual reproductive health public policy. According to Trintapoli (2011:2), existing research on the role of religion in HIV prevention in Sub-Saharan Africa (SSA) demonstrates an essential dualism. On the one hand, religious beliefs, and practices are supposed to influence individuals' sexual behaviour, thus minimising the chance of infection. Risky sexual activity is less common among members of conservative religious minority groups, and among individuals who claim high levels of religious commitment overall, based on to evidence from Zimbabwe, Malawi, and South Africa (Trintapoli 2011:3). One may therefore assume that that religious people in Africa is less likely to use condoms when they participate in hazardous sexual conduct, and in turn increasing the risk of infection.

4.4.2 Church's Response to Sexual Reproductive Health of the Youth

It was difficult to access comprehensive literature on how the church is dealing with sexual reproductive health among the youth in Malawi. This may mean that most of the churches in Malawi did not have formal or a comprehensive or strategic way of responding to sexual reproductive health among youth and adolescents. The little information found was about either the church responding to a single phenomenon or topical sexual issue at that time. For instance, responding to the government position on methods of preventing HIV/AIDS, i.e., condom use, or when the government would like to introduce safe-abortion parliamentary bills. With this little fragmented literature on church's response to specific SHR matters, the researcher was able to establish the position of the church on SRH in Malawi.

Further observation indicates that the church in Malawi seems to be working in a reactive, and not necessarily proactive manner. If the government initiates something sensitive, or in conflict with religious norms; it is when you see religious leaders coming up with press conferences, pastoral letters reminding its faithful and the government church's position on a particular sexual reproductive matter. The church must be proactive by coming up with clear documentation on how to deal with SRH among the youth. This study provides a forum to gather information that may help the church to come up with a strategic means of promoting SRH rather than reacting to initiatives by other interested key players on the sexual life of the youth.

In most cases, the church argues that condom use is against church doctrine; it is a sin, and it is not acceptable on church moral basis. Yet the rate of pregnancies and cases of forced marriages are on the rise in Malawi within and outside church (Mgawadele, 2017). For instance, research conducted in Malawi seeking the opinion of faith community leaders on condom use as a preventive measure for HIV/AIDS received resistance from church leaders. According to Rankin et al. (2008:5), condoms promote immorality. In that study, both Christian and Muslim leaders stated their concern that condom acceptance would promote infidelity and undercut the message of abstinence. They were particularly concerned that condom messages encourage young people to experiment with sex, and offer married people permission to misbehave. Additionally, the religious leaders also stressed abstinence, and marital infidelity as measures to prevent HIV transmission, and these leaders from all groups likewise highlighted the necessity of abstinence and fidelity in marriage for both men and women (Rankin et al., 2008:5).

These value-laden behavioural standards were considered essential to live a religiously ordered life as well as the major (and only) means of limiting HIV spread. In related research from Mangochi District, Gama (2009:184) concluded that "our position as religious grouping is that condoms are not acceptable to be used by our members because condoms encourage sex outside of marriage. In any event, the use of contraception and condoms is unacceptable to our unmarried young people." Gama (2009:184) established again that most Malawians acknowledged the reality of God, and his active presence in the world. There was a widespread belief that everything that happens in one's personal, political, or societal life represents God's will. Based on these religious views, most religious leaders in Malawi oppose the usage of SRH services. While some of them discouraged condoms, most of them also discouraged other SRH

services, particularly contemporary contraception, because conception was thought to be a gift from God. Furthermore, it was widely held in religious circles that the use of condoms and contraceptives could encourage promiscuity.

Trintapoli (2011:8) asserts that as one might predict from anecdotal data, condom marketing is the least preventive action among Malawian religious leaders.
Churches do not just condemn the use of condoms and engaging in premarital sex as a way of enforcing abstinence and fidelity to those in marriage. The research findings of a study conducted by Sara and Trinitapoli (2008:1868) in Malawi showed that church leaders speak regularly about sexual morality during weekly religious service. Sara and Trinitapoli (2008:1868) confirmed that just under half of religious leaders in our sample particularly discussed sexual morality in religious services or sermons every week. Only 5% of these leaders reported that they never discussed it. The discussion of sexual morality in religious rituals is regular and common among denominations. Mission protestants, and African Independent church leaders claimed the most constant inclusions in their weekly services, while Pentecostal and Muslim leaders reported the least. However, people who speak frequently about sexual immorality, and those who speak less frequently do not differ much in their responses to questions concerning sex, saying no to premarital affairs, and fidelity in marriages. In other words, individuals who make a point of discussing sexual morality on a weekly basis have basically comparable ideas on related themes as those who do not; the only difference is the significance they place on incorporating sexuality concerns into their services.

The only way churches appear to be indirectly involved in addressing sexual reproductive health is through faith-based organisations (FBO). Christian Health Association of Malawi (CHAM) is a large faith-based health organisation in Malawi. CHAM is a healthcare network comprising independent church-affiliated facilities primarily located in rural areas. The Malawi Episcopal Conference, and the Malawi Council of Churches jointly own the association. The Catholic church owns almost half of its facilities, while protestant churches own the other half. CHAM facilities provide most of the faith-based service provision in Malawi, and are an important component of the healthcare systems. This study, on the other hand, tries to determine how denominations might directly intervene in dealing with sexual reproductive health among youth. The Church of Central Africa Presbyterian (CCAP) church Synod of Livingstonia is one of Malawi's major denominations and shares the belief of other church

denominations on premarital sex. How is this church dealing with youth sexual reproductive health? The following section includes a discussion of the CCAP Synod of Livingstonia.

4.5 C.C.A. P Synod of Livingstonia and Sexual Health

This section discusses the role and involvement of Synod Livingstonia on the involvement of sexual reproductive health. It also gives a brief history and its departments that provides different social services in the community as a fulfilment of its holistic ministry.

4.5.1 Brief Historical Background of C.C.A.P Synod of Livingstonia

The Central Africa Presbyterian Synod of Livingstonia Church is one of the Malawi's oldest missionary churches. It is in the northern part of Malawi. Its origins can be traced back to 1875, when missionaries from the Free Church of Scotland arrived in Malawi under the leadership of Captain E. D. Young, Rev Dr. Robert Laws, and Henry Henderson (Selfridge 1976: 21; Thompson 1995). Dr. James Stewart requested that this mission be created in honour of Dr. David Livingstone. These missionaries were accompanied by a Xhosa-speaking Lovedale missionary college graduate, William Ntusane Koyi. The missionary party arrived in October of the same year and established a mission station at Cape Maclear. Due to poor health conditions, and the deaths of some missionaries; the mission was later relocated to northern Malawi, and established at Bandawe mission in 1881 (McCracken, 1977:58; Ross, 1996: 20).

Unfavourable conditions continued to affect their work that made them transfer the mission station from Bandawe in Nkhatabay District to Rumphi District at Khondowe Plateau (Mumbwe). They named this mission station Livingstonia under the leadership of Rev Dr. Robert Laws in 1894 (Thompson, 2007:95). In summary, Synod of Livingstonia is a missionary church founded by early Scottish missionaries. C.C.A.P Synod of Livingstonia is a member of the C.C.A.P General Assembly that was founded in 1924 when two churches, C.C.A.P Blantyre, and C.C.A.P Livingstonia came together in 1926, C.C.A.P Nkhoma joined the other two (1995:211-213). Currently, the C.C.A. P. General Assembly has five Synods including the Harare synod that joined in 1965, and the Zambia Synod that joined in 1984 (Chilenje, 2007:39-40). All the mission work of Synod of Livingstonia is characterised by missionary minded approach as it emulates its founders. From its inception till today, the Synod of Livingstonia has been involved both spiritually, and practically in public life within Malawi and beyond. Synod has been involved not only in preaching the gospel and mission of the church but also

for social transformation. Therefore, it is imperative for this Synod to take part in issues affecting the youth in Malawi in the context of sexual reproductive health.

4.5.2 Synod Departments, Institutions and Thematic Areas

The holistic ministries of the Synod of Livingstonia are carried out through its departments, and institutions. These departments, and institutes each have their own mission and vision statements that drive their operations within their respective thematic areas of implementation (Strategic Plan 2008:5). Below is the list of some of the departments.

(i) Livingstonia Aids Programme (LISAP): This helps communities by empowering them to initiate and sustain Christ centred HIV and Aids services. They provide counselling services, among others. Mission and Evangelism exists to coordinate all evangelical programmes within, and to unreached areas within the jurisdiction of the Synod.

(ii) Synod of Livingstonia Development Department (SOLDEV): This department focuses on concerns of relief in emergencies and disasters, as well as initiatives of sustainable agriculture, water and sanitation, and community-based development programmes to promote sustainable livelihoods. Church and Society focuses on issues of human rights, good governance, democracy, and peace building and has mainstreamed issues of gender, HIV and Aids in its project. Additionally, Early Childhood Development (ECD) exists to assist with early childcare, child protection, and food nutrition. It also includes encouraging the construction of early child day care facilities in remote areas where day care centres are few.

(iii) Guilds department: This is responsible for coordinating guilds within the church. Men's guild organises men's ministry in the church; the women's guild organises women's ministry while the youth guild organises all youth activities in the Synod. This department, in collaboration with the Synod health department, is concerned with SRH.

(iv) Synod Health Department: This department exists to coordinate the works of mission hospitals in the Synod under the main body (CHAM). It is this department in collaboration with the Youth Department that has a role to play to make sure that programmes of sexual reproductive health among the youth are well implemented (Strategic Plan, 2008: 6-8).

4.6 Questions of Sexual Reproductive Health of The Youth in the Synod of Livingstonia

Youth Department

C.C.A.P Synod of Livingstonia has shown its commitment to serve the youth in the church and beyond by putting in place necessary structures. It has an established department to oversee all

youth related programmes. The department is headed by an ordained minister who is assisted by Christian Youth Fellowship (CYF) Synodical committee chaired by one of the Youth. This committee is elected for a four-year term at their biennial conference that takes place after every two years (C.Y.F. Constitution, 2016: 7). The youth definition in the C.C.A.P Synod of Livingstonia is those between 14-35 years old. Hereinafter to be called "Youth" or "Young people", so youth and young people can be used interchangeably.

Most of the programmes are carried out using Synodical structures from the prayer house[7] to congregation[8] and presbytery[9] reports to the synodical committee. At all levels, they have a committee that serves a four-year term like that one of the Synodical committees (CYF Constitution 2016: 8). This department collaborates with other organisations doing youth ministry such as C.C.A.P. Students organisation (CCAPSO) which was formed to follow-up Presbyterian students in different learning institutions form secondary school to college and tertiary institutions.[10] This department also coordinates the programmes for girls and boys brigade within the Synod jurisdiction (CYF Constitution, 2016: 13).

Aims of the Youth Department

The following are some of the major aims of the youth department.

1. To direct the youth to Jesus (Mathews, 28:18-20)
2. To help the youth in the ways of following Christ (liaising with parents, guardians, and custodians in providing for discipleship of youth) to ensure the will of God is manifested in the day to day lives and practices of the youth.
3. To help them be good citizens (encourage career development, instil values of Christian family building and orient proper sexual conduct consistent with Christian values (CYF, 2016: 11).

4.6.1 Synod of Livingstonia Health Department Sexual Reproductive Health and Rights Policy

[7] Prayer house is a place where people congregate weekly to worship services. Several prayer houses constitute a Congregation.

[8] Congregation is where several prayers congregate to constitute a congregation.

[9] Presbytery is constituted by several congregation with minimum of five Congregations (Synod constitution 2006)

[10] The aim is to protect youth from false teachings that are common in these higher learning institutions, so they hold on to presbyterian doctrines and teachings.

The C.C.A.P Synod of Livingstonia is anticipated to address SRH, and rights for youth through this department in partnership with the health department. Synod will utilise this Synod SRHR policy as a guide. Synod SRHR policy was created by the Synod health department in accordance with the Ministry of Health's national sexual reproductive health policy. The C.C.A.P Synod of Livingstonia like any other denomination in Malawi however finds it impossible to follow some of the rules outlined in this text, because of prohibition of premarital sex. The impacts of premarital sex are therefore critical issues that must be addressed in the SRHR.

Challenges to Implement SRHR Synod Policy

Implementation of this policy that prioritises and promotes SRHR has some challenges because: (a) There are contradicting messages throughout the policy paper and rules about who can access information and services as well as where, when, and how; (b) there are potentially limited or unclear strategies for disseminating information and services via church organisations such as presbyteries, congregations, other legitimate outlets, and grassroots levels. Harmonisation of the Synod SRHR policy, explicit church moral teachings on sexuality among young unmarried persons (youth), and if applicable, a strategy document are required.

In Article 3.3.9 *Under Young people's health sexual reproductive health policy issue*, the Synod recognizes that young people aged 14 to 35 face numerous issues in Malawi because of new patterns of sexual activity, harmful and cultural traditions, premarital sex, and a lack of access to information on SRH and family planning. These result in unplanned and early pregnancies, induced abortions, STIs, and HIV infections (SRHR, 2016:21). There are no statistics on the number of youngsters involved in premarital sex in the church, but this is the general assessment.

The policy further notes that most young people start having sex at the age of 12 on average. Young persons between the ages of 15 and 24 are more likely to engage in risky sexual behaviour. Despite Christian teaching and morals, young people in Malawi receive information on SRHR issues through peers, schools, and the media. In general, young people are underserved in today's health-care system. SRHR services are not convenient, acceptable, or accessible to young people in places where they are available (SRHR Policy, 2016:21). This is a nationwide issue that includes mission hospitals.

A careful examination shows that, in most cases, SRHR policy contradicts the Livingstonia Synod's ecclesiastical principles for SHR of youth, which prohibits premarital sex between unmarried young people. For example, policy statement on Family Planning, Article 3.3.8 1. states: the C.C.A. P Synod of Livingstonia does not permit unmarried individuals to use contraceptives like condoms, and pills (1 Peter 2: 11; Exodus 20: 14; SRHR, 2016:18). Statement 10 reveals that abortion is not a technique of family planning (SRHR, 2016:19).

Furthermore, Policy document 3.3.9 indicates that "the CCAP Synod of Livingstonia has embraced the Ministry of Health youth friendly services (YFHS) as a standard to fulfil the SRHR requirements of young people. However, this is a contradiction because the Ministry of Health's youth friendly health services packages consist of a package of current contraceptive methods that includes information on tablets, injections, condom, and other methods. If the Synod health department adopts this YFHS, how will the church inform youngsters to use these services? Again, who will provide these YFHS since in the same article statement 1, the church encourages abstinence? How could the church combine the abstinence message with the Ministry of Health's policy that endorses the wholesome package of modern contraceptive technologies of YFHS?

Also, article 3.3.9 statement 1 asserts that all young people aged 14-35 years shall have access to quality youth friendly health services (YFHS) that are safe, guard their right to privacy, ensure confidentiality and provide respect and informed consent while also respecting our Christian values and beliefs (SRHR Policy, 2016: 20). This clause could suggest subscription to safe abortion. These ambiguous and contradictory words in this policy show that doing youth ministry in the church in the framework of SRHR is difficult. It is possible that the policymakers did not seek wider input, or that they are lay males (health professionals) who were unable to persuade church pastors, who are the caretakers of the faith and church traditions. It is a start that they have a policy document. This quandary of coming up with a clear method may also provide a chance for the church to rethink theologically how best to do youth ministry in the context of SRHR.

The SRHR policy in the Livingstonia Synod has a clear goal, and that is to reduce the incidence of HIV and Aids, STI's, unplanned, and unwanted pregnancies, and their complications (Synod SRHR Policy, 2016:21).
The policy statements assert that:

1. All young people aged 14-35 years shall have access to quality YFSH that are safe, guard their privacy, ensure confidentiality, and provide respect and informed consent, while also respecting our Christian values and beliefs.
2. CCAP Synod of Livingstonia shall integrate SRHR messages within the church targeting the youth.
3. CCAP synod shall develop programs targeting parents so that they can communicate with their children on issues of SRHR (Synod SRHR, 2016:21).

Then, policy strategies state thus:

1. To improve availability of and access to YFHS according to our church values.
2. Strengthen behavioural change interventions in the YFHS in morality regarding sex and sexuality among youth.
3. Strengthen research knowledge, and attitudes among young people.
4. Strengthen capacity of clergy and families on YFHS.

Meanwhile, both the policy statements and strategies are contradicting. For instance, policy statement 2 encourages synod to integrate SRHR messages within the church and to target young people, while the church doctrine does not subscribe to the contents of YFHS i.e., mainstreaming, which is fine. The question remains who will be responsible? Is it the youth department, or the health department to come up with a standard message to be mainstreamed considering the sensitivity and controversies that it reflects? Additionally, statement 3 further states that the Synod will develop initiatives aimed at parents to help them communicate with their children about SRHR, yet the parents do not agree with contraceptive policies.

The policy seems good, given that most cultures forbid parents from discussing SRHR with their children, as discussed in Chapter 3. This could be an occasion for the church to break the silence, but the issue is, what has the Synod done to prepare its congregants since the establishment of this policy.? The Synod has to consider making a deliberate programme to orient its faithful's on how to use this policy. As a result, the purpose of this research is to break the silence and see this difficulty as an opportunity for youth ministry in the CCAP Synod of Livingstonia.

4.6.2 Sexual Reproductive Health and Rights Challenges: An Opportunity for Youth Ministry

The church is put in a difficult position where they must support, and teach the Biblical moral standards of abstinence, while also responding to the realities of teenagers who engage in sex

(Magezi, 2016:2). How should the church and society engage in a healthy dialogue about SRHR? There are numerous theological notions that may require the church to see, and respond to SRHR difficulties as an opportunity for youth ministry.

Sexual Rights

Sexual health has been identified as a human rights concern on a global and local scale. Malawi's government has acknowledged all SRHR protocols. As a result, when the church responds to SRHR issues in the context of youth, it is fulfilling one of its tasks of executing the government's commitment to care for people. At the United Nations International Conference on Population and Development (ICPD) in Cairo in 1994, the concept of reproductive health was adopted (UN, 1995: 13). The International Conference on Population and Development (ICPD) had also established the goal that governments should seek to make reproductive health available to all individuals of appropriate ages as soon as practicable, and but not later than 2015.

Similarly, the Declaration and Platform for Action adopted by 187 UN Member States at the Fourth World Conference on Women in 1995 makes it clear that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including SRH, free of coercion, discrimination, and violence"(UN, 1995:39). Meanwhile, equal relations between men and women in sexual encounters and reproduction, including full regard for the integrity of the person, necessitate reciprocal respect, consent, and shared responsibility for sexual behaviour and its consequences (UN, 1995:39).

SRH and rights efforts include those meant to eradicate preventable maternal and neonatal mortality and morbidity, to guarantee quality SRH services, including contraception, and to address sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and adolescent SRH needs. Universal access to SRH is critical not only for achieving sustainable development, but also for ensuring that this new framework speaks to the needs and aspirations of people all across the globe, leading to the achievement of their health and human rights (World Bank Report, 2014: 9). The Malawian Government has therefore created a National Sexual Reproductive Health and Rights Strategy to encourage the use of SRHR knowledge to minimise gender-based violence and harmful traditional practices. Article 3.6.2.1 for instance states: "All young people shall have access to quality YFHS that safeguard their right to privacy, ensure confidentiality, and provide respect and informed consents, while also respecting their cultural values and religious beliefs". Similarly, the National Youth Policy,

article; 2.6.1, known as: Rights of Young People, states that: Every young person is entitled to the rights stated in the Convention on the Rights of the Child (CRC), the Constitution of the Republic of Malawi as well as the Africa Youth Charter, and the Convention on the Rights of the Child (CEDW), among others. These rights include:

1. Right to participate in decision making
2. Right to good health including sexual reproductive health services.
3. Right to protection from sexual exploitation and gender-based violence.
4. Right to education (including sexual information) (National Youth Policy, 2013:5-6).

Therefore, the church under the youth ministry programmes must facilitate that all these rights are observed. To deny the youth these services is like denying them their rights, and thereby violating the constitution.

4.6.3 Synod SRHR Policy Development Strategy

While doing a critical analysis of the existing synod health department SRHR 2016 policy document, it was discovered that some policy statements were contradicting proposed strategies, and the worst being a contradiction with church biblical based moral teaching of abstinence. Therefore, for the synod to come up with a comprehensive policy document this study recommends conducting an empirical study. This empirical study seeks to get the opinion of church elders, ordained ministers, women, and men.

It is also imperative to involve the youth participation so that they have a voice on policy formulation on issues affecting their lives. More importantly, it has an impact on their health and happiness. Involving the youth in policy creation is a matter of human rights, according to Article 12 of the United Nations Convention on the Rights of the Child (CRC), which states that young people have the right to participate in decisions affecting their health and well-being (UN General Assembly, 1989). Furthermore, the African Youth Charter commits to involving youth participation in all aspects of society, including parliamentary decision-making bodies, as well as developing and supporting mechanisms for youth participation at all levels of decision making (e.g., locally, nationally, and continental) (African Union Commission 2006).Allowing teenagers to express their concerns about sexual reproductive health may provide therefore suitable counsel to the church on how to reduce unplanned pregnancies, unsafe abortions and how to prevent the spread of STIs.

4.7 Conclusion

This chapter discussed the general overview of religious attitude on sex and sexual reproductive health among young people. During the discussions, an overall assessment showed that Christianity believes in no sex outside marriage. It appears that all religion has certain misgivings, particularly with some aspects of sexual reproductive health among young people. Their main stance is against contraception for unmarried young people. As a result, it may be difficult for religious people to participate extensively in SRH among young people.

Similarly, the conversations, and findings focusing on churches in Malawi were not dissimilar to the general opinion of religiosity. Churches in Malawi, especially the Synod of Livingstonia, have the same views on sexual reproductive health among young people that have been discussed previously. As fundamental difficulties in the package of SRH are related with premarital sex and modern contraceptive methods, the church in Malawi faces a broad difficulty. The main reason is that the church in Malawi forbids unmarried young people from having premarital sex. As a result, the purpose of this backdrop is to investigate how the church can break the silence by undertaking an empirical study.

The chapter also investigated what the Livingstonia Synod did in response to SRHR challenges in the church. According to the findings, the synod has an SRHR policy that was implemented in 2017. However, a critical analysis revealed that the church is having difficulties using the document due to some contradictory statements within the policy such as abstinence, no contraception for unmarried young people, and encouraging young people to access youth-friendly services at health centres. The following chapter critically examines a theological idea of human dignity to investigate how this theological concept might be used as a theological foundation to address the study's research topic.

CHAPTER 5

SEXUAL REPRODUCTIVE HEALTH, AND THEOLOGICAL PERSPECTIVE ON HUMAN DIGNITY

5.1 Introduction

The previous chapter discussed religious responses to young people's demand for sexual reproductive health. The discussion indicated that religions and churches face issues when it comes to packaging sexual reproductive health services such as premarital sex, contraception, and abortion. This chapter provides a brief history of the evolution of the notion of human dignity as well as a biblical interpretation of human dignity. This chapter additionally offers a critical assessment of human dignity in connection to the repercussions of a lack of SRH among young people, which as presented in chapters 2, 3, and 4, may be deemed a violation of adolescent human sexual integrity from a theological standpoint. This assessment discussion will assist the faith community in identifying a theological and Christian ethical approach to considering the effects of youth sexual reproductive health as a theological challenge and opportunity for youth ministry in the C.C.A.P Synod of Livingstonia as a case study. Unsafe abortion, unplanned pregnancies, early marriages, school dropouts, and hazardous initiation rites are some of the consequences of a lack of sexual reproductive health. Furthermore, this chapter investigates and discusses numerous gender concepts to understand how gender practices affect the sexual dignity of young people. This discussion also includes references to theological understandings of human dignity from chapters 2, 3, and 4. The emphasis on gender is confined to how frequently cultural behaviours reflect and reinforce gender inequity. The chapter also concludes the discussion by providing motivation for an empirical study to learn how the church can consider SRH as a theological challenge and an opportunity for youth ministry in the C.C.A.P Synod of Livingstonia.

5.2 Human Dignity

Only a few theological themes will be covered in this chapter, but human dignity has a very broad and deep theological interpretation. Human dignity in theology can be viewed from several perspectives. However, the following characteristics: human rights, equality, respect, rationality, love, inviolability, and sacredness of human beings' image of God (*Imago Dei*) are all dicussed.

5.2.1 Image of God (Imago Dei)

According to Gondwe (2015:79), the human dignity concept comes from and is centred on the concept of Imago Dei. This viewpoint shows that the idea that humans are created in the image of God, as stated in Genesis 1:27, is the cornerstone of human dignity: "So God created man in his own image, male and female he created them in his own image of God". Furthermore, Cloete (2015:521) argues that human beings are representatives of God on earth through Imago Dei, which reveals the creational standing in relation to God, and fellow human beings on earth. Furthermore, being human is not just an undeserved gift bestowed on humans; it also has ramifications for how we act in front of God (Cloete, 2015:21). Not only do we live before God, but we also respect other people as sacred beings, regardless of gender, social class, age, race, or tribe. All human beings reflect the image and likeness of God and deserves to be treated equally.

Louw (2009:419) affirms that the terms image of God, and nefesj (knowledge of God) relate to human beings' uniqueness as established by their relationship with the living God. The term "image of God " refers to human beings who symbolise God, whereas nefesj denotes that life is depending on God's creative action and fidelity. Humans should concentrate on God and extol God's splendour so that the entire creation is aware of God's existence and grace. Furthermore, Katts (2017:146-147) observes that human dignity derives from the Trinity. People’s dignity is founded on the person and action of God who created us, the God who chose us, the God who provides for us, and the Father who cares for us. Our dignity stems from God that values people so much that He humbled himself and became human in Christ. Therefore, our dignity is founded on the person and action of the Holy Spirit. The following paragraphs discuss certain aspects of humanity's dignity.

5.2.2 Human Dignity and Human Rights

According to Ayodele (2022:8), human dignity is a central value of the international human rights normative system. The author believes that the international human rights system has also accepted the notion that all humans are endowed with equal dignity. The international human rights system is thus founded on the relationship between human dignity and human rights. Although the major human rights treaty texts do not articulate the concepts of human dignity substantially, a reading of the preambles, and relevant provisions suggests that human

dignity is broadly protected in two ways: as a generic respect for everyone's humanity; and as particular protections of individual autonomy (Ayodele, 2022:8). Ayodele (2022:8) further explains that the first conception of human dignity protects individuals from direct attacks against their dignity such as provisions against torture and slavery, while the second protects against indirect attacks against dignity such as protection of the rights to associate freely, or free expression, or to enjoy socio-economic rights.

The concepts of human dignity and democratisation of life to some extents have been inextricably intertwined with the concepts of human rights (Louw, 2014:9). Louw (2014:9) maintains that: "Dignitas means to be human; as a result, dignity has become the key concept in the worldwide struggle for human rights". The author continues that it is particularly difficult to distinguish between rights and human dignity within the human rights discourse. In the same vein, Duplessis (2010:582) claims that "human dignity refers to the state of worthiness assigned to any given human being, or in general, as the state of worthiness assigned to human beings as such". Additionally, Duplessis (2010: 582) states that human rights would then constitute the demands or claims that can be legislated and safeguarded by a so-called Bill of Rights, as is already the case in many modern governments.

Consequently, the goal of the bill of rights in general is assumed to defend and confirm the dignity of human being in the image of God. Koopman (2007:185) agrees that in the fallen world where the weak are abused, must be safeguarded through legal action, especially through human rights. Put legal instruments, such as bills of human rights, that aim to protect the vulnerable. Also, to ensure that life ethos in which the *dignitas* of all human beings particularly the vulnerable group can be protected. Louw (2014:9) also mentions that the paradigm shifts from *dignitas* to the protection of human rights resulted into the main objective of the discussion of the worthiness and value of human beings in the context equal dignity of human beings, that was later recognised by international institutions. According to Louw (2014:9), the reason may be that human dignity, on the other hand, needs human rights concept for it to be understood and have full protection. Human dignity becomes a transient and contextual value in the without concepts of human rights. It is however difficult to talk about human rights without also talking about human dignity.

5.2.3. Equality of Human Beings

Dignitas (dignity) in the ancient world means a person's position and responsibility in the society. The state of one's *dignitas* or social standing dictated one's worth as a human being.

When Christian theologians adopted the term *dignitas*, its meaning shifted dramatically. Dignity is today recognized as everyone's dignity because everyone, is an object of God's love and concern not by social standing. (Brand, 2013:71). Similarly, Cloete (2015:521) highlights the modern sense of human dignity as being completely determined by human beings' own assets and achievement, in stark contrast to the Christian theological approach. The belief is that human dignity is something that no one can attain but is bestowed by God, and so God's activity is not dependent on human capacity. This further suggests that we are equal as human beings despite apparent disparities like gender, race, and social class, because human dignity is given on us by God and is not dependent on any performance or status.

In the same vein, Jurgen Moltman (1984:11) agrees that all human beings are equal in their essence as they reflect the image of God as also declared by the Synod of Bishop in 1974. Indeed, all humans are equal before God, and they deserve equal treatment in all aspects of their existence. Some scholars feel that some people are dignified, and others are not, based on their social standing, such as the disabled, fragile, small, and those who rely on others (Brand, 2013:73). Several theologians, on the other hand, have argued that dependency and vulnerability are not inherently demeaning, but rather fundamental affirmations of human dignity. Dependence and vulnerability are characteristics of God's image in humans (Brand, 2013: 73). Brand (2013: 74) echoes that recognizing reliance as well as vulnerability as an expression of the Image of God guides in mitigating the pains of our fellow human beings. We depend on each other out of love and the same love wants to bring healing and relief to those who are suffering. (Galatians 6:2).

In addition, the understanding of equality in the Old Testament is within the realm of justice. The basic structure of Israelite society had to be ordered in such a way that the interests of the weak were cared for (Brand, 2013:74). In agreement Koopman (2007: 185) explained, that Torah protected the vulnerable; part of the harvest should be left for the poor and strangers (Lev.,19:9; 23:22); and disabled people are to be honoured (Lev., 19:14); old people should be respected (Lev.19:32); strangers should be treated with respect (Lev.,19:33) since they are equal in dignity to Israelites (Lev., 24:22; Num.15:19). The theological implications behind this concern for the poor and weak is that inequality leads to bondage of the weak and those perceived as inferior. Furthermore, inequality promotes human rights violations, racism, and oppression which is against the will of God for every human being.

In Galatians 3:28, Apostle Paul emphasises that "there is no Jew, nor Greek, neither slave nor free, neither male nor female; all are morally and spiritually equal before God". This passage underlines the importance of valuing something other than the image of God (Imago dei) in how one thinks about others and oneself because doing so goes against the intention of God who created humans in His own image. Considering this, since humans are made in the image of God, they are theologically equal in position before God and their fellow humans (Vorster, 2012:5). Katts (2017: 148) further states that human dignity is a created dignity, which means that we obtain our dignity from our creator. Our dignity is unalienable because it was bestowed upon us by the creator. It is inalienable since it does not originate with humans, but rather with the creator. It is inalienable because it is not dependent on the recognition of dignity by the frail, untrustworthy hearts, brains, and actions of humans, but rather on the living God. As a result, creaturely dignity is received with dignity that cannot be lost due to vulnerability.

5.2.4. Inviolability of Human Beings

The image of God not only grants equal dignity to all human beings, but being cast in this image of God also means that this dignity is precious, inviolable, and has equal status with God and fellow human beings. People deserve respect and honour equal to their status by virtue of being in this image (Gondwe, 2015:81). No one is thus permitted to directly or indirectly damage or injure the image of God in people. Martin Luther King Jr. (in Burrow, 2002: 231) believes that since God is the source of human dignity, it cannot be given or taken away. Mankind was formed in the image of God, he is therefore distinct from other creatures, and his similarity to God gives him a unique value that ensures the inviolability of every human. Relatedly, every human being must be protected from any form of violence, direct or indirect.

The most prominent articulation of this inviolability is the prohibition against murder as a death crime, as: "whoever sheds blood of a man shall shed his blood; for in his image God made man" (Genesis 9:6). This language expressly forbids humans from killing one another. Benedict XVI (in Kirchhoff, 2009: 589) reveals that the defence of human dignity is the first and ultimate fundamental right and should be the standard that inspires and leads all efforts. Human dignity must not be degraded to the level of commercial price at any cost.

Some scholars have opposing perspectives on the divine image's permanence in man, believing that this dignity is conditional. According to Kraynak (2003:85), either the entire human species or individuals who commit immoral acts such as murder might undermine or partially

lose the divine image. Similarly, Du Plessis (2010:582) adds that stemming from the doctrine of total corruption of humanity by sin, reformed theology traditionally had severe reservations about the idea of the intrinsic dignity of human belongs and generally opted for supplementary definition of dignity; human dignity, which was irrevocably lost due to original sin, is restored only through redemption through Jesus Christ and the work of the holy Spirit.

In other settings, according to Du Plessis (2010:582), dignity might be achieved through brave conduct, courage, or the worth of some virtue. Tongeren (2013:158) emphasises that the relationship between God and humans is nonetheless said to be constitutive, meaning that it cannot be introduced later or from outside. It further implies that it cannot be erased either. Only the creator has the ultimate authority to end human life. There is no one who is not related to God. Furthermore, the relationship affects the entire human species because it defines human beings as human beings and will thus be present in everything that makes them human.

5.3 SRH Practices, and Human Dignity

This part tries to assess the discussions in chapters 2, 3, and 4, and determine whether the discussions in these chapters truly degrade human dignity. The aim of this research is to explore and find appropriate theological counsel that can assist the church in breaking the silence on SRH among the youth. Some of the causes reported to be harming juvenile dignity under SRH include SRH policies, cultural practices, religious beliefs, and social structures of various countries. Human dignity, as previously stated critically, is an inherent gift bestowed by God on all humanity. This dignity is not to be violated in any form, and it is not to be degraded in any way. Human dignity must be affirmed in the church and in public life. A dignified existence is distinguished by a joyful quality of life in all areas of life from spiritual, social, physical, psychological, and emotional well-being. All these elements contribute to what it means to be a human being.

Notably, unwanted pregnancy, which may lead to unsafe abortion or maternal death, STIs, and early and forced marriages are all harmful repercussions of an absence of competent SRH care among youth. The implications of the negative results of a lack of sexual reproductive health may impede youngsters from living lives that affirm their human dignity. Furthermore, the youth may be unable to contribute effectively to the economy of the country, families, and churches, resulting in a society trapped in a vicious loop of poverty.

Most youths are in adolescence, where they are maturing, and they require good theological dignified sexual reproductive health counselling. As shown above, if individuals do not receive sufficient sexual reproductive health care, may face a variety of life-threatening issues that may negatively affect their general wellbeing.

5.3.1 SRH, Religious Beliefs, and Dignity

This paragraph tries to conduct a critical analysis of how religious beliefs presented in Chapter 4 may be theologically considered affecting the SRH of youth. The aim of this critical analysis is to provide meaningful theological direction to the church for it to preserve the dignity of SRH of the youth. Religion is vital in society since it not only provides spiritual guidance but also moral and social support to people. Religions, among other things should consider its social/moral obligation to care for or protect the SRH of youth. How do religious beliefs influence the sexual reproductive health of young people regarding human dignity?

(a) Universal Contraceptive Methods

When governmental policy contradicts religious beliefs or when religious activities contradict public policy, there is always a conflict. Addressing concerns of SRH, religious communities confront some significant hurdles. Many religious organisations have serious qualms about providing unmarried young people with widespread access to contraception services. Most of these contraceptives are purely scientific methods that have been embraced by sexual reproductive health public policy.

From the standpoint of religion, infertility, premarital sex, condom use, and advocacy for safe abortion are all sins (Olusola & Jegede, 2014:91). This theological viewpoint has placed the church in a quandary on how to maintain Biblical moral teachings to children as the government urges the church to promote universal sexual reproductive health public policy. Proponents who regard access to contraception as an essential human right for all young people want church involvement in advancing universal SRH public policy. However, it was noticed that religious beliefs prevent unmarried teenagers from accessing contraceptive services, with an emphasis on abstinence. As a result, the church may be guilty of violating human dignity by denying youth essential human rights to access information and health care services. Individuals do who may not use contraception and engage in hazardous activities, they are more likely to encounter sexual difficulties such as unplanned pregnancies unless they opt for unsafe abortion. The church may be honouring its values by outlawing condom use,

extramarital sex, and access to any type of contemporary contraception. Furthermore, if one found pregnant outside wedlock is expelled from the church.

Agha et al. (2006:551), in Zambia, churches such as the Seventh-day Adventist restrict premarital sex to unmarried young people and those engaged in premarital sex are suspended from church. According to their church policies all suspended members stop receiving holy communion. The question is, though, how effective is this abstinence education? Furthermore, the practice of suspending a girl from church may be regarded as a gendered violation of a girl's human dignity. So, why are girls the only ones suspended? What about the person responsible for the pregnancy? All human beings are equal in dignity who deserve equal treatment.

In view of the fact that the church continues to reprimand or suspend girls from church for having children outside of marriage is undeniable proof that very few young people follow the abstinence teachings. If she does not terminate the pregnancy, she will bear a child, and will be unable to care of it. It is apparent that the youngster may not receive adequate care in order to grow into a dignified social and healthy adult. This child born outside of marriage may face social rejection, which is a violation of human dignity. Such children will grow up in poverty, perpetuating the vicious circle of poverty while also undercutting human dignity principles. The question therefore remains, how can the church that believes in holistic ministry of serving people spiritually and physically promote sexual reproductive health?

In this context, however, the faith community is pushed to reconsider its theological position and Christian ethics on SRH and the execution of public policy of universal access to contraception among (unmarried) youth. Public policy promotes sexual reproductive health among the youth both inside and outside of the church. By limiting adolescent access to sexual reproductive health, the religious community may be indirectly accused of undermining the dignity of the youth. Unwanted pregnancy, unsafe abortion, early marriages, school dropouts, and STIs can all come from a lack of sexual reproductive health. Magezi (2016:2) reveals that Christianity often advocates abstinence instead of use of condom, which is contrary with reality. When adolescents and youngsters thereby involved in sexual activities can easily contract HIV or get unwanted pregnant that will finally affect their economic participation of their nation.

5.3.3 Sexual Reproductive Health Policies, and Human Dignity

Another significant hurdle to faith community to fully engaging in SRH is the association of premarital sex with sin. Meanwhile, religious leaders avoid discussing sexuality openly with young unmarried people (Erikson et al., 2010:104). Should churches maintain their silence when the dignity of youth is jeopardised? In other words, the church may be assumed to be discreetly supporting the negative results of a lack of sexual reproductive health, which harms the well-being of kids. Could the church not see this as a challenge and an opportunity for youth ministry considering the above-mentioned theological view of human dignity? There are several areas noted in the discussion as highlighted below.

(a) Poor Health Services Delivery

According to the World Health Organization, universal access to SRH is critical to sustainable development goals, but also the realisation people's rights to access health care services. (World Bank Report, 2014: 9). Furthermore, the Child right protection policy includes important safeguards of adolescents such as right to health care and information that will contribute to meaningful moral wellbeing (World Bank Report, 2014). Any nation, organisation, or institution that fails therefore to provide sexual reproductive health services to their youth may be contributing to the degradation of the youth's dignity, either directly or indirectly.

Nevertheless, due to inadequate health systems, most African countries, including Malawi, continue to face obstacles in providing UN convention rights to youth. There are various factors that may jeopardise the delivery of SRH services to Malawi's youth. Another problem, as Chandra-Mouliet et al. (2015:32) describes, is a lack of medical workers in rural clinics. Adolescent vulnerability to poor SHR is exacerbated by a lack of services that are friendly to the youth and lack of proper information on the awareness of contraceptives usage and safe sex. Another issue identified was insufficient health infrastructure in some rural regions, which contributes to poor sexual health and reproductive services. Most rural hospitals have insufficient equipment. Where there are hospitals, they are located far apart and have a poor road network for simple transit (Chandra-Mouliet et al., 2015:32).

As previously stated, a denial of access to SRH information by bad health service delivery systems may be regarded as depriving the youth of their basic needs of information, and so a violation of human dignity denies young access to such services.

(b) Lack of Privacy/Poor Attitude

Furthermore, research conducted by Munthali et al. (2004:24) suggests that most youth prefer traditional healers to clinics or hospitals for STIs. They feel that traditional healers provide seclusion during the healing process. Youth at health facilities are afraid of being humiliated by hospital employees. Furthermore, in most situations, facilities offer SRH services together with adults and young people. This often demotivates young people since they may not be free to interact with adults (Munthali et al. 2004: 24); MDGS, 2015-2016).

Another problem is denying young people right to privacy as they mix with adults when they come to the health centre to obtain contraception services. This does not only violate the right to privacy, but also denies the youth access to health care. These circumstances make it difficult for young people who require sexual reproductive health care to obtain them. In healthy systems, a lack of facilities, a negative attitude toward youth, and a lack of privacy remain to be an obstacle to SRH. Denying youth sexual reproductive health services is denying them their creator-given right to human dignity (Munthali et al., 2004:24).

As a result, if youth do not have access to sexual reproductive health services, maternal mortality, neonatal mortality, and morbidity will be high. Therefore, efforts must be done to ensure quality SRH services among the youth.

5.3.4 Sexual Reproductive Health, and Gender Inequalities in Human Dignity

5.3.4.1 Gender as a Social Construction

Gender is a broad topic that is defined differently in different situations, and it is a continuous debate, as various experts argue. It is not therefore the intention of this paragraph to discuss gender concepts in details but will limit its discussion to how gender inequalities affect sexual dignity of young people. To some gender is understood in terms of social roles expected of a man and a woman (boys and girls) and some understood it in terms of biological roles (Rolleri, 2012a:34). According to Rolleri (2012:34), these features, actions, and roles are learnt and reinforced through the socialisation process that continues throughout the life cycle.

Thatcher (2011:18) concurs that gender social constructs start from the birthday of a child by identification of sex organs. The baby is then outfitted in a way that corresponds to the gendered duties that the newborn must play. If it is a boy, he is mostly clothed in what society considers to be boy's apparel; if it is a girl, the same is true. Similarly, Pilcher and Wheleham (2004:59) define gender as male or female based on natural traits indicating clear gender distinctions.

Pilcher and Wheleham (2004: 59) maintains that anything concerned with social process that produces distinctions between male and female is regarded gendered. Furthermore, Courtenay (2000:1387) explains that it is learned rather than innate. Individuals are referred to as agents in the construction (and deconstruction) of masculine and feminine norms. Additionally, Adam (2000:105) observes that gender is not regarded as an inherent property of humanity. But gender is regarded as a social construct of certain characteristics with socio-cultural elements that are implemented in different ways within a cultural setup.

Furthermore, Dworkin et al. (2012:114) suggest that gender is what a woman or man can do or can't do in a particular social environment as a social construct. According to Whitehead and Barret (2001:34), gender is a "socially constructed set of relations in a social-cultural setting based on biological roles such as reproductive systems". Thatcher (2011:18) adds that the institutions that comprise our society are inherently gendered and serve as sites for the gendering of individuals and interactions. As a result, comprehending gender in this context leads to gendered roles. Roles assigned to people based on their gender.

5.3.4.2 Patriarchy and Gender

The male representation of God originated in the ancient Near East, and it is a natural reflection of the time's patriarchal culture (Klopper, 2002:421). God is portrayed as masculine throughout the Old Testament, as a parent, king, majesty, judge, shepherd, ruler, warrior, and other male images of the time. These representations of God "culturally relate to the time and space in which they were conceived" (Klopper, 2002:421). Klopper reveals further that the images of God are related to the value assigned to them. Klopper (2002:422) further argues that "Human beings, when speaking of God, quite naturally choose language which will project into the divinity the highest value that they hold.

This view of God's image becomes the foundational rationale for male dominance, forming patriarchal society. Claassens (2008:49) also explicates that an exclusive male image of God contributes to the social construction of male superiority, establishing and reinforcing patriarchal practice. This social construction, based on God's perceived maleness, will likewise have an impact on social practices. Claassens (2008:49) further argues that a primary image of God as a patriarch or male ruler will contribute to a culture in which male rulership is seen "at the least, as normative, and at the worst, as divinely sanctioned," with the male presented as normal and the female as marginal, a position that many women internalise. As a result,

patriarchy and its associated prejudice against women is a fundamental impediment to men and women working together. The patriarchal system refers to power dynamics in society in which men work together to maintain their dominant positions. Unfortunately, this type of activity can be seen in various cultural rituals as well as in some religious practices.

Chisale and Phuthi (2023:144) mention that gender inequality is a thorn in African communities. It affects all women due to patriarchy, and religion that enforce women's submission and silence. Patriarchy informs the systems of domination that to the abuse of power by men. Meanwhile, understanding gender from patriarchal view became an emerging issue for feminist theologians to fight against this gender imbalance. According to Phiri (1997:11), it is this construction of womanhood by patriarchy as one of the central arguments for feminist theologians globally and particularly in Africa, because it has influenced roles, and how women are treated in and outside the church. Patriarchal has defined women as inferior to men, thereby perpetrating the oppression of women by religion and culture (Phiri, 1997:11).

The creation story in Genesis was seen as the Biblical foundation for the subordination of women. It was interpreted as saying that woman was created from man, after man, and for man's advantage. Genesis 3:16 was taken to be a divine law that man should be the head of a woman (Phiri, 1997:49). Phiri (1997:11) adds that this interpretation was enhanced by the understanding that Jewish culture of the Bible is also Patriarchal. The result of such gender disparity has also led to hierarchal institution.

Interpreting scripture in this context has contributed to the violation of the dignity of women, robbing them of their God given values since every human being is created in God's image, and thereby deserves honour and respect. Chisale and Phuti (2023:145) similarly mention that women's humanity, as all human beings are also created in the image of God. This implies that the image of God is universal to all human beings.

Therefore, there must be a will from the churches to find a way to fight against gender inequality, and gender-based violence in the church, and outside the church. Moroever, Chilongozi (2022:77) states that the other way of ending gender inequality is through intensification of human rights education, and by making both men and women understand that they are both created in the image of God. Being in the image of God therefore deserve equal respect, and status in the society. Kapuma (2000:351) argues that both men and women are designed and valued internally. As with the poor, when a woman is stripped of values, moral, and dignity; it is God who is being oppressed.

5.3.4.3 Gender Equality

According to Douglas (2007:3), gender equality is a state realised when men and women, boys and girls, have equal chances, rights, authority, responsibilities, and life projects. Douglas (2007:4), on the other hand, highlights that this does not suggest that men and women are the same, but rather that their possibilities and responsibilities are not dictated by whether they are born male or female. It is also vital to highlight that gender equitable practices must be in place for gender equality to occur. Without equity, people do not have equal access to resources and opportunities that allow them to function as equals in society. In other words, there are gender inequities in which women and "the feminine" are frequently discounted while males and "masculine" features are prized. Men frequently rule decision-making in personal, community, and governmental settings, and women's needs and interests are ignored or not handled equitably. The acquired belief that men should keep authority always places women in situations that endanger their health and well-being in such communities (Courtenay, 2000:1387).

Essentially, the church has a responsibility to work toward gender revolutionary policies and initiatives through youth ministry. Gender equality policies that aim to disrupt traditional gender conventions. The transformative approaches can productively address gender based sexual violence and other hierarchies of advantage and disadvantage between men and women.

5.3.4.4 Gender Justice

Gender justice continues to be a debatable concept with some referring to it as a recognition and protection of all people's rights regardless of gender differences (Douglous, 2007:4). It also involves the use of gender-sensitive measures in their promotion and protection (Douglous, 2007:4). In other words, gender injustice refers to policies and programmes that purposefully or accidentally promote or exploit gender inequities.

5.3.4.5 Gender Equity

Gender equity is the process of treating male and female species equally regardless of social status. Gender equality considers socio-cultural background impediments that denies female and male from working on the same level (Douglous, 2007:4). (Douglas, 2007:4). According to UNESCO (2003:2), gender equity can be considered to an end, whereas equality can be viewed as the aim. Gender equality, can be similarly described as strategies that accommodate gender variations and inequities to achieve project goals.

As mentioned in the preceding sections, dignity refers to an inherent trait of merit in individuals. Worthiness attributes qualify both men and women for equal regard and recognition. Dignity is a God's given attribute to all human beings equally regardless of gender differences of men and women (Koopman, 2015:21). Historically, the concept of human dignity is recognised in all three religions, namely Judaism, Christianity, and Islam (Claassens et al., 2003:7). Religions, via their teachings and practices, have a role to play in promoting, supporting, and safeguarding human dignity. This has therefore become one of the criteria for arguing for gender equity in the implementation of church-based youth ministry in this study.

Considering the preceding paragraph's discussion of human dignity, as well as gender justice as promoting civil rights in relation to gender equality, some gender disparities can be clearly noticed in how some cultural traditions treat females, as explained in Chapter 3. A good example is the cleansing initiation rites[11] .One wonders why boys, are not prepared for their male roles in the same way they do with girls. Why are the boys not given older women to sleep with them as they also prepare for the future roles? This may be deduced as one way of gender-based violence of girls' sexual rights. In this context therefore, girls may be experiencing gender injustice as well as gender unequal treatment to their counterparts who are boys. In cleansing initiation rites, girls' *diginitas* has been reduced to mere sex objects by being forced to sleep with someone not of their choice.

In the same chapter 3, it was also noted that girls are forced into early marriages under *kupimbira* and *Skazi or mbirigha cultural* marriage practices. It is only girls that are forced to marry older men. Little is known whether boys are also forced in this type of marriage as a cultural practice. In this regard, this could be also classified as gender-based violence against the girl child. Sexual violence that undermines human dignity. Early, forced marriages lack fairness in promoting equality between boys and girls. Therefore, the church is challenged to deal with practices that undermine the dignity of the girls in the name of cultural practices.
In the guise of selective gender justice, there are certain evident components of gender-based violence. In the instance of an unmarried pregnancy, it is usually a female who faces disciplinary action, such as being suspended from church and denied sacraments. As a result, girls face gender injustice, which leads to gender imbalance behaviours.

[11] Where girls are forced to sleep with an elderly man (*fisi*, hyena) as a way of preparing girls for their future women roles.

The church has a role to promote equality in dignity of male and female species with an intention of promoting justice (Koopman, 2015:28). Douglous (2007:4) observes that gender justice requires assessing access to rights for women and young people as a way of promoting justice and safeguarding them from abuse. The church's role in implementing sexual reproductive health as a theological challenge and opportunity for youth ministry must therefore consider tactics that promote equitable justice among children regardless of gender identities.

Finally, there are notable gaps in the quest of promoting dignity of the lives of the youth. One can assume that the custodians of culture did not consider the worth of human dignity when constructing cultural norms and behaviours. The church must also decide how to view this as a theological problem and an opportunity for young ministry through the perspective of human dignity. The following is a proposal on how the church should address alleged abuses of human dignity in sexual reproductive health practices among teenagers.

5.4 Youth Ministry, and SRH through the Lens of Dignity

The aim of this discussion is to explore and illustrate how a lack of sexual reproductive health among youth and its harmful consequences has been a violation of human dignity. The conversation then moves on to consider what role the church could have in attempting to defend the dignity of youth under SRH services. Although the concept of human dignity is utilised in academia and public conversations in every field it is difficult to define it. Accordingly, it may be useful to discuss that human dignity is eroded when there is lack of human basic needs. (Koopman, 2007:178). The previous section's critical examination revealed several gaps in sexual reproductive health in cultural practices, lack of implementation of universal SRH services, poor governmental policies, and religious views. The lack of SRH among the youth represented a severe threat to human dignity. The discussion in the chapters above revealed several difficulties in defending the dignity of youth.

5.4.1 Church (Youth Ministry), and Sexual Reproductive Health

Although the church lacks the legal authority to draft policies for the state based on its theological concept of human dignity, it also lacks the authority to contradict cultural caretakers to safeguard the dignity of young people. The church could however consider SRH as a theological and ethical matter that requires scholarly attention focusing on human dignity and sexual rights (Kotze, 2019:2). Human rights concept was developed soon after second world

war. Thereafter, several rights also were developed including sex rights (Davids, 2019:69). This proclamation serves as a framework for the church to engage in theological and ethical reflections.

Therefore, the church by nature of its calling is in the mission of restoring human dignity. The restoration could be done within its boundaries and possibly beyond. The church must base in the Trinitarian concept of human dignity in quest of restoration of human dignity (Koopman, 2007:180). Koopman (2007:180) further observes that we are compelled by the inherent dignity and worthiness of human beings to create an environment that promotes desirable human living conditions.

As youth religion formation may not be discussed outside socio-cultural framework where youth are found (Weber, 2014:115). Equally the violation of the dignity of young people due to lack of SRH services cannot be discussed without considering cultural influences. Weber (2014: 115) note, cultural practices, experiences, and norms have both negative benefits on faith formation of youth. Churches, families, and faith leaders must also consider ways to improve disordered sexual development of young people (Weber & Bowers, 2018:7) Local churches must acknowledge the environment of violence, and that congregations must also regard it as God's mission to care for the vulnerable (Weber & Bowers, 2018:6).

As a church, the challenge is to re-evaluate its attitude to sexual problems after witnessing the terrible living health conditions of young people due to lack of SRH. How can the church give its all? Empirical study is subsequently required to hear diverse people's perspectives on what should be done. This study tries to develop a constructive and theologically informed approach of dealing with youth SRH without jeopardising Biblical faith or breaching youth rights.

5.5 Conclusion

The chapter investigated numerous aspects of theological, and social political interpretation of human dignity with a focus on inviolability of human beings. The discussion further noted that all human beings are equal in dignity and must be free from violation as they carry the image of God. Consequently, denying young people sexual reproductive health exposes them to violent scenarios. Unwanted pregnancies, unsafe abortions, early marriages, forced marriages, and damaging cultures were some of the repercussions of a lack of sexual reproductive health noted.

The chapter also discussed how some harmful cultural practices were considered a violation of human dignity, as well as how some religious beliefs were considered a violation of human dignity by denying the youth information about SRH due to unwillingness of the church to speak openly about SRH. In addition, certain health facilities do not provide SRH services to youth.

Finally, it has been argued that if the church seeks to implement SRH of youth from a theological perspective, must focus the inviolability, equality of human beings. However, during the conversation, it has been noticed that some cultural behaviours and basic religious views are at the forefront of eroding the sexual dignity of the youth. Some traditional rituals, including sexual cleansing rites and forced marriages (*kupimbira, Skazi, kutomera*), expose the sexual lives of youth to risky sexual activity. Some cultural traditions violate the sexual dignity of young people by encouraging gender-based violence. Notably, girls are more likely compelled to marry and sleep with older men to prepare for their future gender roles.

Moreover, conservative doctrines of abstinence, and no sex outside marriage limit youth access to universal sexual reproductive health public policy. Furthermore, by refraining from discussing sexual reproductive health public policy in the church, this silence may result in bad SRH results such as early marriage, unsafe abortion, and school dropouts. If they drop out of school too soon or marry too soon, they will be unable to contribute to the meaningful family economic development. The chapter discussed determinants that prevents young people to access SRH services such as inadequate qualified staff, and lack of suitable environment for youth. This poses a threat to the dignity of the youth. This chapter, therefore, suggests conducting an empirical study, and soliciting the perspectives of church leaders and youth on SRH as both a theological issue and potential for youth ministry.

CHAPTER 6

RESEARCH METHODOLOGY AND DATA COLLECTION

6.1 Introduction

The chapter explains the technique and methodological procedure utilised to gather and analyse data in order to meet aims of this study. The aim of collecting data was to investigate and learn from church members what they know or experiences about the role of church in SRH among the youth. Furthermore, the study aims to find out how the church may regard breaking the silence on SRH among the youth as a theological challenge and opportunity for youth ministry.

This chapter explains in details how the research study was designed and methods used, including sample process, information data gathering procedures, data analysis procedure and ethical standards. It is an empirical study based on qualitative research that encourages participants to express themselves and comprehend (William, 2006:3).

6.2 Research Design

This paragraph outlines a detailed study design that was used during this research study. The study adopted a qualitative study design. Selection of an appropriate study methodology is determined by the nature of the research. The fundamental goal of qualitative study design is to grasp deeper insights of the phenomenon (Opoku et al., 2016:32). It also emphasizes people's experiences as opposed to quantitative research designs, which employ numbers (Babbie et al., 2001:270). However, like every other method, qualitative approaches have both advantages and downsides.

Qualitative research has some disadvantages that includes difficulty to generalizing findings. Also, data obtained is likely to be biased or representative of a small population (Gilbert, 2018:30). Cassim (2021:44) observes that qualitative research methods are at times expensive and subjective. Subjectivity was difficult to maintain for the researcher, who has the same characteristics as the subjects who is a member of the same religion. With this constraint in mind, the researcher purposefully asked participants for as many empirical data as feasible. The researcher, and his assistants were time conscious so that participants should not lose focus and interests.

This qualitative technique helped this research achieve its goals by allowing interviewees to voice their perspectives based on how they viewed SRH issues in the church. This method of conducting semi-structured interviews with elders and ministers was beneficial since it allowed the researcher to better understand how church principles are viewed and misconstrued. Furthermore, the youth's experiences were crucial to the narrative strategies used in the focus group talks.

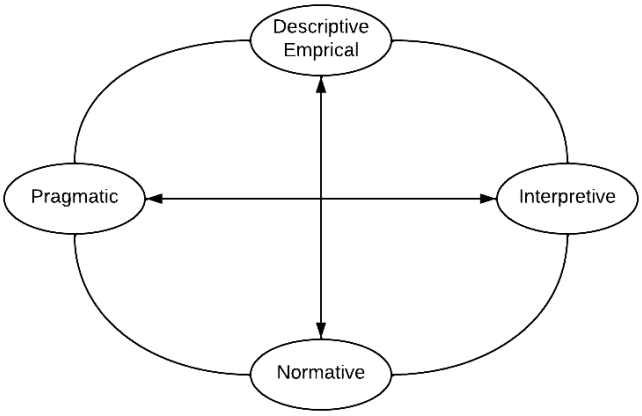
6.3 Interpretivism Research Philosophy

The interpretative paradigm of task of practical theology is assumed in this research study. Importantly, practical theology is a discipline on its own, however, it also engages in discussion with other subjects (Osmer, 2008:163). In addition, practical theological interpretation by congregational leaders is essentially cross-disciplinary (Osmer, 2008:163).

This study as an interdisciplinary study on SRH therefore used Osmer's model. The four practical theological activities tend to answer three questions. (i) What has been going on? (ii) What is going on? (iii) What should be going on? These problems are addressed by focusing on Osmer's four tasks of practical theological interpretation listed below.

a) *The descriptive-empirical task,* which entails collecting data that helps us discern patterns and dynamics in particular episodes, situations, or contexts.
b) *The interpretative task,* which entails drawing on theories of the arts and science to better understand and explain why patterns and dynamics are occurring.
c) *The normative task,* which involves using theological concepts to interpret episodes, situations, or contexts, constructing ethical norms to guide our responses, and learning from "good practice".
d) *The pragmatic task,* which entails determining strategies of action that will influence situations in ways that are desirable and entering a reflective conversation with the "talk back" emerging when they are enacted (Osmer, 200:4).

The interpretative methods are clearly defined in the below diagram.



Four tasks of Practical Theology Fig 1.

Osmer's technique was chosen because youth ministry includes practical theology: a methodical study of theory, practice, and practical theology methodologies, as discussed in Chapter 1, sub-section 1.2.2. There is substantial literature that mentions youth ministry as a form of practical theology. Dean and Root (2011:17) contend, for example, that youth ministry is a sub-discipline of practical theology and that practical theology studies are the interception of God's actions with human practices, circumstances, and situations. Nel (2003:67; 2005a:9) also advocates for the synergy of youth ministry and practical theology, claiming that youth ministry is a sub-discipline and practice of practical theology.

The inquiry began with a descriptive empirical task of obtaining information through available literature from several disciplines, existing church practices in the context of sexual reproductive health among youth, and field work data collection.

This was followed by the development of theories through the interpretative task of youth ministry as practical theology to understand why these dynamics occur in various fields of life, and later through the normative task of youth ministry as practical theology to interpret theological concepts, situations, or contexts and construct ethical norms to guide our responses. Finally, the pragmatic task assisted this research in determining and recommending.

The findings of the research studies were interpreted using the third of four normative tasks of practical theology. According to Osmer (2008: 152), the normative work of practical theological interpretation focuses on good practice, which provides excellent practice from the

past to the present to reform a congregation's current acts. This activity should produce new perspectives on God, the Christian life, and societal ideals that go beyond what is supplied by accepted traditions. The study went on to incorporate ethical reflections, which use ethical principles, rules, or guidelines to steer action toward moral purposes (Osmer, 2008:161). This strategy contributed to answering the study's research questions by investigating what the church is doing or how it can regard SRH among teenagers as a theological issue and potential for youth ministry.

6.4 Unit of Analysis

The most fundamental item of inquiry for which data is collected is the unit of analysis. This could be a social group, an individual, or an organization (Lewis-Beck et al., 2011:1). The church members of the CCAP Synod of Livingstonia were the unit of analysis in this study. The members who participated in the study were youth, male and female church elders, and ordained church pastors of word and sacrament. The information gathered in this survey determined how church members wanted SRH among teenagers to be viewed as a theological problem and potential for youth ministry.

6.5 Research Participants, and Sampling Methods

6.5.1 Pilot Study

Pilot research for in-depth semi-structured interviews and focus group discussions was undertaken prior to the main empirical study. This pilot study was conducted at Katawa CCAP church with demographic groups that were like the research sample groups. Those who took part in this pilot were not among the sampled participants. According to Cassim (2021: 146), a pilot study is necessary before doing a testing exercise to get input on and optimize a research method, procedure, or tool.

In this pilot study, two elders (one male, and one female), and one minister were involved in the semi-structured interviews. Two youths (a female, and a male) were also interviewed in the focus group discussions (FGD). The number of participants was not considered much since the researcher was interested in checking whether the formulated questions were understandable.

During the pilot study, the researcher realised some anomalies, which made the researcher change the approach during the actual semi-structured interviews, and focus group discussions.

The researcher noticed that taking notes while someone is talking was not effective hence, he decided to use a voice recorder and transcribe later. It also transpired during the pilot study that the youth were shy to open to some questions when the researcher, who is a minister[12], was moderating the focus group discussion, but were free when one of the research assistants took over as a moderator of the FGD. Therefore, this made the researcher to take a supervisory role during the actual FGDs. Nevertheless, all the questions proved to be understandable.

The pilot study assisted the researcher in ensuring that he has the necessary instruments to gather the necessary information. This was helpful in the sense that the pilot study respondents would mirror the study sample as much as possible (Cassim, 2021: 146). During this pilot study, the researcher was assisted by two research assistants who were first oriented on research ethics, however, the research did not have many problems to adopt the skills since both were third year students at Mzuzu University. The researcher engaged the research assistants to assist him during the FGDs sessions. While one was a recording secretary, the other was asking questions, and the main researcher was taking a supervisory role. Observably, most of the youth were very free in responding to questions regardless of the presence of their church minister as the main researcher as we thought they might not be comfortable with the church minister. During the analysis, the assistant researchers were coded WD, thus representing their actual names, Willan and Debora respectively.

6.5.2 Sampling Methods

The study adopted the sampling method.

6.5.2.1 Purposive Sampling

Purposive sampling methods, which is a non-probability sampling strategy matched with qualitative research (Babbie, 2016: 187) was used in this research. This sample strategy was considered because it can lead to information that allows individuals to openly voice their opinions (Creswell, 2012: 206). Purposive sampling is effective because it selects persons who are aware of the subject under study and have vital characteristics that match the research objectives (Sensing, 2011:83). This sample approach instructed the researcher to select the participants who met a specific requirement. These participants were selected from the church ministers, and elders who decide church policy (Presbyterianism); and some teenagers.

[12] "Minister" refers to the parish minister or Pastor in charge of the congregation.

This research sampled two presbyteries [13]out of 34 presbyteries in the C.C.A.P (known as Synod). One was in the rural setting, and the other in urban setting. This was done to balance the viewpoints of urban and rural people on the church's policies. As it was not possible to interview all presbyteries, these were chosen as the representatives. Furthermore, because this is the first study of its kind in the synod, the findings may inspire others to conduct similar studies with a larger population. It is also worth noting that, among all the sampling methods such as snowball sampling, critical sampling, and cluster sampling, this study chose cluster sampling because the presbyteries are all constructed in the same way.

The interview consisted FGDs, and semi-structured interviews for individual participants. Two FGDs were conducted in the two selected presbyteries. Each of the two youth focus groups had six people (three females, and three males) from two presbyteries, had a total of twelve (12) participants. Based on the CCAP Synod of Livingstonia's definition of youth, all the youth chosen were between the ages of 14 and 35. Youth were considered to represent youth perspectives on the issue under the study. The sample size for the semi-structured individual interviews was ten people (ten) from each presbytery, with five ministers and five elders; thus, totalling twenty (20) participants 10 male and 10 female participants respectively. All the elder participants were between the ages of 40 and 65. The church elders represented the church's general membership. All these add up to a sample of 32 participants.

Meanwhile, the ministers[14] were considered in this exercise to determine policies of the church, while the elders were there to determine their perceptions about sexual reproductive health among the youth in their locality, in line with their religious beliefs. The youth were the concern of the whole study. In most cases. the sample size in qualitative research is limited, this form of sampling thus allowed the researcher to obtain more significant data analysis (Babbie, 2016: 187). Given that the sample size was very limited, it was thought prudent not to overgeneralize. Despite the small sample size, the concept that influenced the choice to use it is that "quality is more important than quantity" (Sensing, 2011:85). Babbie (2016: 187) adds that while qualitative research strives to gain an in-depth understanding of a phenomenon, a small sample size facilitates case-oriented analysis.

6.5.2.2 Euthini Presbytery

[13] Presbytery comprises at least five congregations and is led by Presbytery Moderator who is assisted by the Presbytery Clerk.

[14] Ministers refers to ordained ministers serving a congregation in the CCAP Church. It is synonymous with a Pastor.

Euthini Presbytery is a synod presbytery located in the countryside. It is made up of six congregations. At the Euthini Presbytery station, focus group talks and semi-structured individual interviews were held. Five preachers, five elders, and six teenagers were from the following congregations Kapando, Kamubanga, Mbalachanda, Mwitha, and Kumulaza; and they congregated at Euthini Presbytery station. As some of the participants had travelled to the station, the researcher offered them with beverages and snacks. Due to a lack of funds, the researcher requested that the presbytery identify individuals from a walkable distance.

6.5.2.3 Mzuzu Presbytery

Mzuzu Presbytery is in Mzuzu, and it contains nine churches. Like Euthini Presbytery, five ministers, and five elders from the following congregations: Kachere, Lupaso, Zolozolo, Katawa, and Chiputula were interviewed. A FGD was also held with youth from the same congregations. Refreshments were served to all attendees. None of the participants travelled a long distance because congregations in Mzuzu Presbytery are close, as opposed to rural areas where congregations are spread apart.

6.6 Data Collection

The data for this study was collected from October 2022 to January 2023, after ethical approval from the Stellenbosch University Research Ethical Clearance Committee (REC)was given to the researcher at the end of September. Data collection was delayed, contrary to initial anticipation since the research was considered medium risk, and needed ethical clearance before data collection. Focus groups FGDs were utilised to collect data from the youths, and semi-structured in-depth individual interviews were employed to obtain responses from the pastors, and the selected church leaders.

6.6.1 Semi Structured Interviews

Semi-structured interviews are data gathering procedures that include open-ended questions that allow for an in-depth dialogue (Creswell, 2012: 214). Open-ended questions were employed in the study. According to Babbie and Mouton (2001:233), open-ended questions are one of the possibilities that can be used in an empirical research project. The use of open-ended inquiries has the advantage of allowing respondents to provide their responses without being constrained by the question. The use of open-ended questions allowed respondents to go into deeper depth in expressing their opinions with additional information. Semi-structured interviews also allow the interviewer to ask follow-up questions based on the responses of the participants. Furthermore, semi-structured interviews were chosen over structured and unstructured interviews because respondents can provide comprehensive personal information

in semi-structured interviews, and the interviewer has control over what type of information is sought (Creswell, 2012: 218).

Another advantage of semi-structured interviews is that they facilitate the collection of rich and thick descriptions and the detailed exploration of topics from a smaller sample. Participants are actively involved, and provide direction to the interview, and the researcher can follow up on both verbal and nonverbal communication (Fouche et al., 2021 :358). In addition, Adres (2012: 70) comments that there is low bias in face-to-face interviews. Relatedly, Pattern and Newhart (2018: 162) argue that face-to face interviews allow researchers to note factors such as intonation, gestures, and facial expressions that convey the meaning of what is said. The downsides of semi-interviews include that the information presented is filtered through the interviewers' perspectives and the informants may not always supply the perspective that the interviewer desires (Creswell, 2012:218). Furthermore, Fouche et al. (2021: 358) state that the main disadvantage of semi-structured interviews is that they take time from both the researcher and the participant. However, the researcher was aware of these difficulties and conducted this research with the understanding that none of the disadvantages listed should have an impact on the findings.

Twenty participants were recruited for the semi-structured interviews as indicated above. The interviews were held at the presbytery station office where interviewees could easily gather, and be accessible to the interviewers. All the interviews for these ministers were conducted in English, while the interviews for the elders were conducted in both English, and Chitumbuka. After that, the data was captured, transcribed, and analysed.

6.6.2 Focus Groups Discussions

Focus group talks are a qualitative data collection strategy in which a heterogeneous or homogeneous group meets to engage in group discussion on a suggested topic to obtain various qualitative data (Fouche et al., 2021: 361). Greeff (2011: 360) likewise adds that FGDs are group-based interviews intended to collect data from participants who have traits, and may feel more comfortable sharing opinions in a group than in a one-on-one interview. This strategy, however, has both advantages and problems.

For instance, participants can debate one other's points of view while collecting various data, which is one of the benefits. Focus groups are useful for getting information on topics that have

not yet received widespread coverage (Fouche et al., 2021:363). The researcher was however aware of some of the disadvantages of this method. They include group dynamics that may impede smooth group discussions. Other disadvantages are members who dominate, or members who are quiet, or group members who are shy and do not share their unique opinions on topics; and the inability to ask in-depth follow-up questions with specific individuals (Fouche et al., 2021:363). The interviewer's duty in this exercise was to manage the conversation while taking notes.

During the focus group talks, the researcher was aided by two research assistants, one male, and one female from University of Livingstonia. These research assistants received research ethics training to do the exercise professionally. One was filming, and the other was regulating. The researcher acted as a supervisor while also providing guidance. The main reason for engaging research assistance for this focus group was to give a chance to youth to express themselves freely who could not have done so in the presence of a minister when discussing sexual matters.[15] The research assistants were in the same age range of the interviewees (18-35) years old, so they were peers.[16]

6.7 Design of Questions, and Topics

In qualitative research, questions must be prepared ahead of time in order to lead the study in obtaining the necessary information; nevertheless, follow-up questions may occur as the interviews go on (Dawson, 2009:70). The design of the questions and subjects was based on practical theological themes that emphasise socio-cultural and religious reform toward optimal SRH services for youth. Most of the questions stemmed from discussions in Chapter 2 (about some sexual health determinants), Chapter 3 (i.e. some harmful cultures about SRH), Chapter 4 (about the church's ambivalence on SRH), and Chapter 5 (i.e., some theological concepts like human dignity and gender.

The purpose and goals of this qualitative research for youth, elders, and ministers for both FGDs, and semi-structured interviews were to find out what the Synod of Livingstonia is doing or not doing on sexual reproductive health issues among youth. The study also hoped to identify

[15] Traditionally in church youth may not be free to talk about sexual matters as part of respect as they consider a minister as their parent. The study considers these to be effects of silent culture on sex matters.
[16] This was a deliberate choice to pick peers to moderate the FGDs so that they are free to talk and make follow-up questions.

treatments that the church could use to address sexual reproductive difficulties among young people based on the outcomes of this study. Furthermore, the study aimed to reply to the question of how the church may regard SRH as a theological issue, and as an opportunity for youth ministry.

6.7.1 Design of Questions for Interviews and Group Discussions

All questions were designed so that respondents would feel at ease explaining what they know about the church's role in matters concerning the SRH of the youth. The questions also allowed respondents to indicate potential challenges and opportunities for the church in dealing with youth sexual reproductive health. In an ecclesiastical context, questions were designed with a focus on youth, church elders, and ordained clergy. The sections below show the issues that were addressed by the questions used in both semi-structured interviews and focus group sessions.

6.7.2 Topics Covered

This qualitative study project addressed numerous issues concerning sexual reproductive health among young people, including church beliefs, theology, culture, national health policy, gender, and human dignity. However, some questions for the FGDs, and the semi-structured individual interviews did not use the same phraseology, and the topic, depending on what the researchers intended to hear from each group.

6.7.2.1 Knowledge on Sexual Reproductive Health Among the Youth

The researcher wanted to see if the respondents knew anything about sexual reproductive health and where they acquired most of their information, if any. The researcher also sought to know if they were aware of any repercussions of a lack of information on SRH as well as if they were aware of any youth-friendly services or sexual reproductive policies in the country.

6.7.2.2 The Role of Culture on Sexual Reproductive Health

Regarding this topic, the researcher wished to know if respondents knew anything about their culture's approach to SRH issues among the youth in the research area. The researcher also wanted to know what culture is doing well or poorly in terms of SHR among these young people. Furthermore, the researcher wished to know if the respondents were aware of some negative cultural practices and their consequences. The researcher was also interested in learning about their perspectives on how culture may address SRH issues. Furthermore, the

researcher wanted to know if culture had an impact on how churches should approach SRH , and the implementation of policies.

6.7.2.3The Role of the Church on Sexual Reproductive Health

The researcher also wanted to know what the church was doing or not doing in terms of sexual reproductive health among young people. The researcher wanted to know if church members were aware of teenage sexual rights as outlined in the constitution and national SRH policy. Furthermore, respondents were asked to clarify whether the church had any established methods of dealing with sexual reproductive health among youth. Respondents were also questioned if they were aware of any detrimental effects of silence on SRH, and the repercussions of a lack of SRH. Furthermore, respondents were asked to indicate what the church should do better or not do in response to SRH issues.

6.8 Ethical Considerations

Prior to collecting empirical study data, the researcher guaranteed that the study followed the ethical issues of Stellenbosch University's Research Ethics Committee (SU REC), a Division for Research Development Under the Social, Behavioural, and Education Research (SBER). During the research procedure, people's privacy needs to be maintained (Rubin & Babbie, 2007:37-38; Dawson, 2009:153).

The SU REC approved the proposal after some changes were made to some documents and the letter to undertake empirical research was granted (see appendix one). The Livingstonia Synod also granted authorization to undertake research within synod presbyteries (see appendix 2). Flyers were put on the notice boards of the various congregations urging youth to participate in this exercise. Furthermore, each participant was required to sign ethical clearance form from the Stellenbosch University confirming that participants were willing to participate in the interview. The letter indicated that individuals could withdraw at any point if they felt unable to continue with the study.

In addition, given the nature of the exercise and the recommendation from Stellenbosch REC, a letter from St John of God Hospital, a psychosocial counselling institution was issued to offer such services if necessary. All participants, both in focus groups and in individual semi-structured interviews were promised that all data collected would be kept anonymous, and that no names would be associated with the findings. All raw data and information were stored in safe systems. As much of the work would be done in presbyteries, fliers encouraging volunteers

were created and posted on the venue's notice boards (see appendix 3). Apart from the Stellenbosch University's clearance letters, and the Synod of Livingstonia's authorization letters, consent letters were acquired in accordance with the Stellenbosch University Ethics Committee's policy. Each participant was asked to grant consent to participate in this exercise.

Since this study included human participants, care was taken to ensure that data was not gathered at the expense of the participants' well-being (Strydom, 2011:113). Throughout the process, the researcher protected the confidentiality and anonymity of all the participants (Sarantakos, 2013:20). The participants were also informed by the researcher that the findings will be shared with them.

The researcher guaranteed the subjects that they would not suffer any physical, or emotional harm through this study (Sarantakos, 2013: 18-19). Keeping this in mind, and on the advice of Stellenbosch REC, a letter was sent to St John of God hospitaller services offering counselling services (see appendix 4). This was done to repair the emotional damages that would arise in case the interviews triggered unfavourable emotions from the interviewees. Fortunately, no one experienced anything as such during the interview. The participants were also informed that this was a voluntary experiment, and that they might opt out at any time. Following the interviews, the researcher provided beverages and snacks to all the participants as a courtesy.

6.9 The Field Work Experience

Almost all participants that took part in this research exercise were very cooperative during the interview and focus group discussions process. They looked comfortable with the discussion especially the FGD because the moderators and the secretary of the group who were the research assistants were almost of the same age group. However, some participants at some point digressed from the main questions. They felt like they now have an opportunity to speak out their mind on somethings that the church was not doing well, which was not related to the topic understudy. In this case, the researcher gave them a chance to do so but without losing focus of the study. On a different note, it was a clear indicator that the participants enjoyed the interaction, although it was discovered that the in-depth interviews consumed a lot of time. They were, however, very enriching as it gave an opportunity to obtain important information.

6.10 Data Analysis and Procedures

Data analysis is the goal of qualitative research. Data analysis involves refining, elaborating concepts, themes, and events.

6.10.1 Organization of Data

The data collection tools used in this study were semi-structured in-depth interviews, and FGDs. The data collection took five months from September 2022 to January 2023 after being cleared by Stellenbosch University REC. The delay was due to two reasons, namely delay in being cleared by the ethics committee; and lack of sufficient resources to conduct these empirical studies. Data from the focus group discussions, and the semi-structured interviews are organised and presented in the succeeding chapter 7. The data collected during this study remained confidential. The researcher also maintained anonymity by using letter codes e.g. church Elders as CE, church ministers as CM, and focus groups as FGD1, FGD2.

6.10.2 Transcribing the Data

Data must be organised into file folders or computer files at an early point in the analysis process. The files are then converted to appropriate text units, usually words, for manual or machine analysis (Fouche, 2021: 403). The data preparation phase includes transcribing. If data has been recorded using technical means, transcription is a vital stage in the interpretation process, and for many qualitative researchers, it is the initial step in data analysis (Fouche et al., 2021:403).

At this step, one transcribes from the audio what was said and how it was said (Fouche, 2021:373). In this study, the interviews were transcribed in the original language (Chitumbuka), then translated into English, and then translated back into the original language to compare the two versions of the transcripts. This method enhanced authenticity, ensured precision, and could be used to verify the reliability of the data analysis process (Fouche, 2021:373).

6.10.3 Coding Data

Coding is a way of focusing our attention on what matters, incidents, emotions, perceptions, actions, reactions, events, phenomenon, and subtext (Vanover et al., 2021:113). In addition, De Vos (2005:338) notes that a code is a word or phrase drawn out of the data that has been coded. A coding system, therefore, helped to reduce the data to a manageable set of themes or categories that could be written in the final analysis. Henning (2009: 101) reveals that it is imperative to fully capture the collected data to allow a logical flow of thought in addressing the research question.

The coding process in this study was done using Atlas.ti software. The ATLAS.ti Software is essential in qualitative research as it is used to analyse qualitative data. (e.g., focus group discussions, and interviews). Open axial, and selective coding are used to identify the resemblance, the difference, and thereafter compare. The process was helpful in answering the research question.

6.11. Data Analysis

Data analysis aids in the organisation, structure, and interpretation of large amounts of collected data (De Vos, 2005: 333). The goal of data analysis is to maintain original perspectives of research participants while extracting critical information relevant to the study's aims. Non-numerical tests and data interpretation were used in this study due to its primary goal of determining how the church can break the silence about sexual reproduction as a youth outreach strategy. Focusing on the study's aims and objectives while attempting to answer the research question, data was assessed utilising the church's practical theological framework in addressing youth ministry concerns.

The study adopted thematic analysis as an appropriate method to analyses qualitative data at the end of all the interviews and group discussions. The transcribed data was analyzed, and summarized using tables. The tables were helpful in grouping information and highlighting the different themes that developed during the focus groups. According to De Vos (2005:335) this process is at the heart of qualitative data analysis.

6.11.1 Data Storage

Taking care of and protecting research data from loss necessitates the use of strong security techniques for data storage, backup, transmission, and disposal (Corte et al., 2021:135). There are numerous reasons why data storage and security should be prioritised, including future use

and personal information secrecy. Data security entails paying attention to physical security, network security, and computer system and file security to prevent unauthorised access or undesired modifications to data, as well as disclosure or destruction of data (Corte et al., 2021: 139). In this case, data for this study was kept in a computer locking systems with a password and installing a firewall system. Secondly, hard copies were kept in a lockable cabin that was well secured.

6.12. Reliability and Validity

Validity was another step taken in this research study. Validity in qualitative research is linked with trustworthiness, and credibility (Golafshani, 2003:3). In the same vein, Creswell (2009:190) argues that validity in qualitative research refers to the "steps that are employed in a study to check the accuracy of the findings". It is therefore the responsibility of the researcher to examine and ensure that the whole research process and outcomes are both valid and reliable (Henning, 2009:148). Moreover, validity is considered one of the strengths of qualitative research methods, and it is based on determining whether the findings are accurate from the standpoint of the researcher, the participant, or the reader's account (Creswell, 2009:191). Relatedly, Schutt and Chambliss (2006:207) argue that validity of qualitative research results is enabled by a truthful account of challenges the researcher experienced with participants during data collection, and steps taken to address the challenges faced.

In Henning's (2009:147) view, reliability is different from validity, and it is not limited to accuracy only, but also to the use of techniques to produce the reliable results. Therefore, one of the techniques one can use to confirm the reliability of the findings of the study is by listening to the recorded audios repeatedly. Listening to these recordings ensured the correct capturing of the information supplied by the participants.

6.13. Reflexivity and Limitations

Reflexivity is a mode of knowing which accepts the impossibility of the researcher standing outside of the research field and seeks to incorporate that knowledge creatively and effectively (Swinton & Mowat, 2006: 59). When one is conducting internal research, she or he is always subject to personal biases and preconceptions. For instance, the researcher has been a member of CCAP, and an ordained minister for a good number of years in the same church. The researcher made some decisions that he will respect the findings from his respondents. One of the limitations of this study was that all interviewees in both FGDs, and semi-structured in-depth individual interviews were from one denomination CCAP Synod of Livingstonia. No

other members of other denominations participated in this interview because the specific study was targeted at the Synod of Livingstonia.

The research was conducted to understand that issues of SRH among the youth, and church beliefs are quite complex and sensitive. The study however maintained its critical objectives and unravelled that SRH among the youth is a theological challenge and opportunity for youth ministry in the CCAP Synod of Livingstonia.

6.14. Conclusion

This chapter provided a detailed account of the description of qualitative data collection methods used to answer the research question. It also presented comprehensive steps and procedures of the whole research project highlighting planning, execution, and necessary changes during the research process. Finally, the chapter discussed the validation of the findings. Research experiences, reflexivity, and limitations were also discussed. All questions that were asked during the FGDs, and semi-structured in-depth individual interviews were in line with the research question. The next chapter presents a report on the findings from field work.

CHAPTER 7

DISCUSSION OF FINDINGS

7.1 Introduction

The previous chapter discussed the methodological approach adopted to collect data, and how the data was analysed to achieve the objective of this study. This chapter discusses the findings from the FGDs, and the individual interviews. The findings derived from the data collected aim to answer the research question of this study on how the C.C.A.P Synod of Livingstonia will break the silence on SRH, and see it as a theological challenge, and opportunity for youth ministry.

The discussion is focused on the responses from the FGDs, and individual interviews as inspired by their knowledge, experience of what is happening, and what they feel could be done better. The results directly reflect what the respondents shared during this data-collection process. The data was collected using both English and Tumbuka languages, and then translated into English afterward. The discussion of these findings is reported according to the five objectives of this study. The discussion of the findings is based on themes identified during the thematic data analysis process. Furthermore, the findings are linked to previous studies by showing their (dis)similarity where necessary. The respondents of individual interviews were ten church elders, and ten ordained ministers, and youth who participated in the FGDs. All the questions used for data collection are attached in the appendices.

7.2 Brief Profile of Presbyteries

It is important to know the demographic, and socio-political status of the researched communities as it helps to analyse people's perceptions from a specific context.

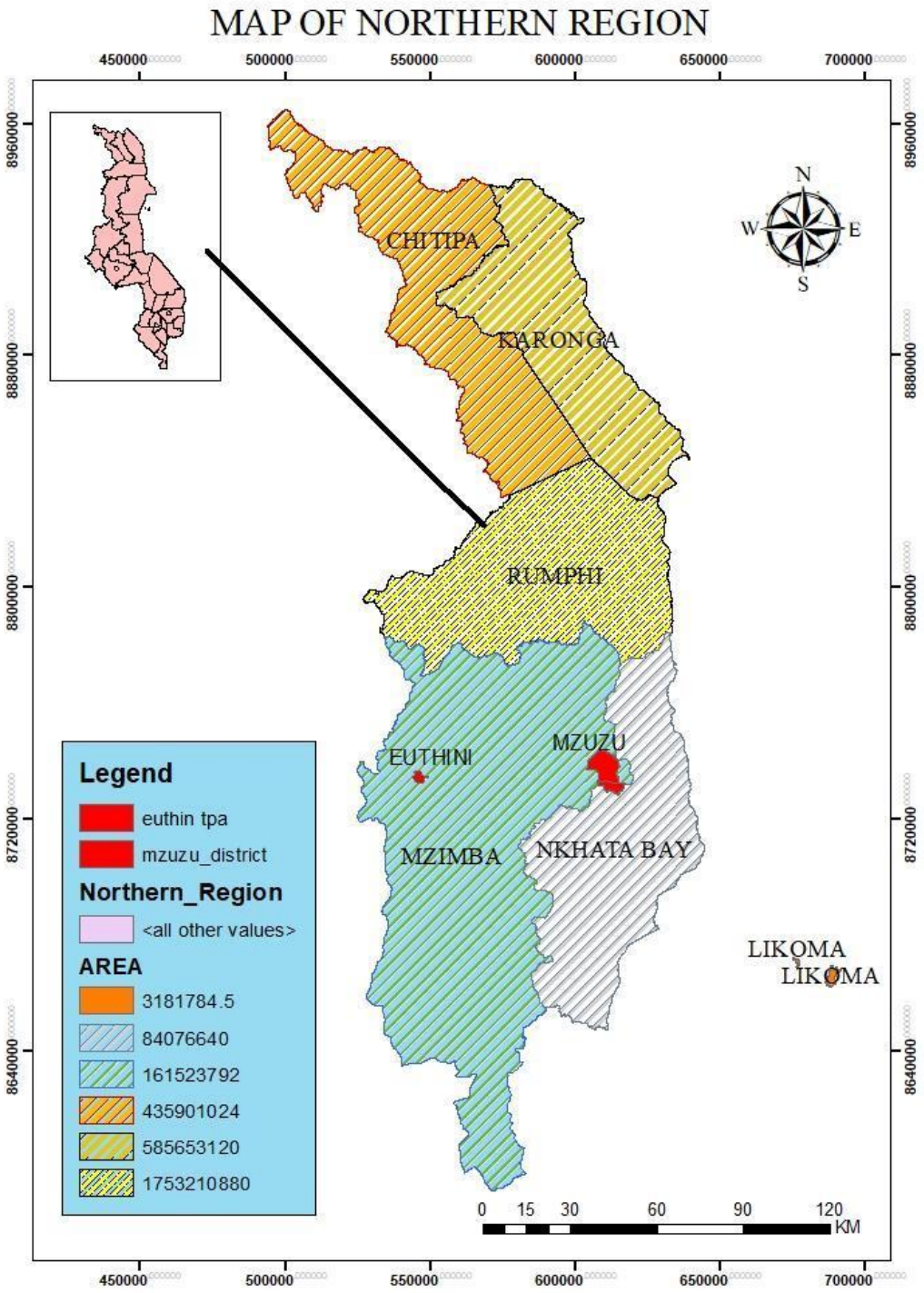


Figure 1: Map of northern region of Malawi showing the catchment area of Livingstonia Synod, and indicating Euthini and Mzuzu Ppresbyteries

7.2.1 Euthini Presbytery

Euthini Presbytery is one of the Presbyteries of the CCAP Synod of Livingstonia. The Presbytery comprises six congregations. This is in the rural setting of the synod among the mixture of two tribes, Ngoni and Tumbuka people. However, Tumbuka language is spoken much more than Ngoni. It is a predominantly patriarchal culture. This presbytery was chosen to represent the views of the rural congregation's people.

7.2.2 Mzuzu Presbytery

Mzuzu Presbytery is one of the city presbyteries found in the city of Mzuzu, and it was named after this city. This presbytery is constituted of nine presbyteries. It is one of the biggest presbyteries in the Synod. It was chosen by the researcher for being capable of representing the views of the urban community. In this presbytery, there is a mixture of tribes, but Tumbuka is a predominant language, and there are few other languages.

7.2.3 Profile of the Respondents

The respondents of this empirical study were members of the CCAP Synod of Livingstonia only. The first was a FGD comprising of youth of both genders aged 18-35. In total, we had twelve youths, and were classified into two FGDs, one for Euthini Presbytery, and the other one for Mzuzu Presbytery. We also had individual interviews with ten church elders, five from Euthini and five from Mzuzu Presbyteries respectively. We also interviewed ten ordained ministers, five from each Mzuzu and Euthini Presbyteries respectively.

7. 3 Presentation, and Discussion of Findings

Here is the discussion of findings from semi-structured interviews from the FGDs, and in-depth individual interviews from church elders and ordained ministers. The analysis is presented in order of the research objectives.

7.3.1 Knowledge of the Importance of Sexual and Reproductive Health (SRH)

Objective 1 of the study

Before discussing the importance of SRH, it was imperative to first pose a question on respondents' understanding of SRH, and its related concepts. The focus group discussion interviews with the youths, and the in-depth individual interviews with church elders and ministers revealed that most of them had some understanding of SRH concepts as highlighted in **section 2.2**. Although, most of the respondents did not clearly define SRH, it was interesting to learn that most of them were able to mention components of SRH.

In a group of six participants in a focus group, it was discovered that at least four were able to mention components of sexual and reproductive health. To that effect, this FGD results

indicated that youth were familiar with family planning, prevention of pregnancy and STIs, and safe sex. Although it could be said that they were familiar with some SRH concepts, most of them did not express themselves on safe abortion. This suggests that the youth view abortion as a sin as it remains an illegal practice in Malawi.

On the importance of SRH, both FGDs, and individual in-depth interviews with church elders and some ordained church ministers revealed that most youth and parents appreciate the importance of sexual and reproductive health education. They were however quick to note that the church has some problems embracing the wholesome package of SRH as some elements conflict with their Biblical beliefs as discussed below. Most of the youth indicated their sources of SRH as peers, media, and school subjects.

FGD1: *"We often get information about sexual and reproductive health from our peers, social media, and television, and rely on school curricula to provide us with accurate information".*

Another respondent agreed and appreciated the role of television in giving them information on SRH.

FGD2: *"We get information from television from different organisations such as PSI that share very well-defined sexual and reproductive health programs. They talk about contraceptives and safe sex methods which our parents, at times, condemn when they see this on TV".*

However, many parents had refused to investigate the importance of SRH programmes as pertained to the youth, thus leading to the condemnation of such SRH programmes. It was also noted that some youths could even define SRH based on Population Services International's (PSI) adverts on the radio.[17]

Another focus group member also observed that as much as they appreciate SRH programmes from the media and some organisations, some people still condemn these programmes.

FGD 1: *"Many people view sexual and reproductive health as an abomination that teaches and encourages premature sexual activities that will encourage abortion among the youth".*

[17]Population Services International is an international organization in Malawi that is involved in sexual reproductive health services nationwide.

Basd on the above finding, it means that people express negative perceptions mostly about abortion in relation to SRH. Many argue that issues of abortion are very controversial, so it is deemed unethical for someone to carry out an abortion despite risking the health of a woman or girl. Sexual and reproductive health programmes also centre on such issues and address them globally through the World Health Organization (WHO). WHO has concluded that quality abortion care is a critical part of the universal right to health and essential to protecting the health of women and girls everywhere (WHO, 2022:14). The youth in the focus group however observed that parents condemn SRH because it encourages abortion. Concerning abortion, one Church Elder **(CE)** explained thus:

CE 1: (Church Elder) *"Abortion is not completely denied by the church. It is acceptable on certain conditions, especially for married women. For instance, an abortion can be carried out if the mother has internal bleeding and her life is at risk upon recommendation by a medical doctor but not otherwise".*

Another church elder based on the knowledge he had about SRH as at the time of this study highlighted the dangers of unsafe abortion. In other words, he was acknowledging that unsafe abortion is taking place in his community.

CE 3: "*From the best of my knowledge, I have in most cases learned that unsafe abortion has led to several complications among women. Women who perform unsafe abortions end up dying or even have serious complications in their reproduction systems. Access to safe abortion services is essential for young people to make informed decisions about their sexual and reproductive health, and it is important that young people are provided with accurate information about the risks and benefits of abortion. The challenge is how to teach youth openly about this because it is more of encouraging youth into promiscuity".*

The above finding is in line with earlier studies that have shown that unsafe abortion is a major cause of maternal mortality and morbidity, especially in low- and-middle-income countries (WHO, 2019:2). Zulu et al. (2019:5) confirm that access to safe abortion services allows young people to make informed decisions about their sexual and reproductive health. Zulu et al. (2019:5) further note that access to safe abortion services should be coupled with comprehensive sexuality education, as this can help prevent unintended pregnancies and reduce the need for abortion. This requires a concerted effort toward increasing awareness of SRH

among the youth. Research has also shown that access to safe abortion services alone may not be sufficient to reduce the incidence of unsafe abortion, as in some countries the legalisation of abortion is not enough to ensure access. Therefore, policymakers must consider the broader context when considering access to safe abortion services. Moreover, SRH is an important aspect of people's overall health and well-being, particularly the youth.

Some church elders expressed their knowledge, and the importance of SRH as follows:
CE 2: "*Sexual, and reproductive health programmes are not harmful at all; in fact, they are very beneficial to the youth growing up in this modern age full of technology. Sexual reproductive health is important for young people as it can help them make informed decisions about their health and well-being. However, in the church, we are still not comfortable talking about it since some of the contents of the sexual reproductive health package contradict our teachings of faithfulness and abstinence".*

While the church elders acknowledged the importance of SRH, the church ministers who were also interviewed had their own opinions on the issues of SRH as shown below.

CM1: *"I know that comprehensive sexual health education, access to contraception, and access to safe abortion services are all essential components of sexual reproductive health for young people. Young people must be provided with accurate and comprehensive information about sexual reproductive health to make informed decisions about their sexual and reproductive health. Young people must also be able to access sexual reproductive health education which is comprehensive, inclusive, and skills-based to provide young people with the tools they need to make informed decisions about their sexual reproductive health. Young people should have access to healthcare services and resources related to sexual reproductive health. However, this requires a well-organised approach so that we do not compromise our Christian beliefs".*

While acknowledging the importance of SRH, another church minister quickly condemned the manner in which it had been advertised by both electronic, and print media houses.

CM2: *"As much as I acknowledge the importance of sexual reproductive health, I have a problem with the media and how it advertises these products. It is promoting promiscuity among the youth so as a church, we need just to depend on prayer rather than telling our*

unmarried young people to practise safe sex or use contraceptives. No, no God will punish us for that…unless we find a better way of teaching our young people about sexual life".

In summary, after analysing responses from the above three groups of the respondents, it was found that the youth from the FGDs, , church elders, and church ministers had the knowledge, and they appreciate the importance of SRH. They further noted that their church policies are too conservative to embrace, thus exposing their young people to the important services of SRH. They however suggested that SRH can be improved in the church through policy changes and investment in youth-focused interventions. It was concluded that SRH is an important and complex issue with implications for the overall health and well-being of young people, and the need for increased focus and resources to better support youth. Importantly, young people are at a critical stage of their development, and they need access to accurate and comprehensive sexual health information to make informed decisions.

Furthermore, studies have shown that young people in developing countries are more likely to be denied access to information and services related to sexual reproductive health than their counterparts in developed countries (Dixon-Mueller, 1993). Moreover, there is a lack of culturally relevant sexual reproductive health education that is tailored to meet the specific needs of young people. As a result, young people are often exposed to inaccurate information, which can lead to risky behaviours and health complications. Comprehensive sexual health education should also address the potential harms of gender stereotypes and stereotypes about sexual orientation, which can lead to further marginalisation of certain groups (Leung et al., 2019:623). To ensure that young people are supported in their decision-making, it is necessary to address any potential risks and harms that could result from comprehensive sexual health education.

This response above from both the church elders, and ordained church ministers through the FGD, and in-depth individual interviews implies that individual members of the church do appreciate and recognize the need and the importance of sexual reproductive health among the youth. All the respondents further noted that SRH would be able to provide the youth with skills on how to handle their sexual lives. The challenge remains the teachings that may not be able to implement some of the SRH packages such as contraceptives among the youth as the church is very conservative on the teachings of abstinence. This means that we will have to review teachings.

One church elder **(CE)** lamented thus: *"We need to review some of our church practices as the world is also changing".*

The FGD interviews revealed that most youths in rural areas as compared to urban youths were experiencing inadequate access to SRH as at when this study was being conducted. Such a thing may thereby plunge them into more danger.

The key informant results also confirmed that people in the past did not have adequate access to sexual and reproductive messages, a thing that had contributed to an alarming rate of poverty levels in Malawi. Despite the acknowledgment from both FGD interviews, it was revealed that most parents did not discuss the topic with their children as indicated by one CE thus: *"Issues of sex are very sensitive to be discussed by parents. We have left this issue in the hands of NGO's".* The results from the FGD interviews had shown that many parents have played a less significant role in the SRH programmes that pertain to the youth. In theory, parents prefer to appear unaware that their children are involved in sexual or reproductive activities.
For instance, FGD 2 stated thus:

"Our parents know that we hear about SRH issues from other sources such as the media because sometimes TV or radio messages pop up when we are together and sometimes, they immediately request to change the channel, so they pretend a lot".

The above suggests that parents have not been educating, supporting, and listening to their children about SRH because the parents believe that doing so would be like encouraging fornication. This is done with the intention of safeguarding their young people.

7.3.2 Social, and Cultural Factors that Influence Perceptions of SRH in the Context of Synod of Livingstonia

Objective 2 of the study

This section examines the social, and cultural, factors that influence perceptions of sexual reproductive health in Malawi. In Africa, specifically Malawi, these factors have a significant

impact on perceptions of sexual reproductive health. The findings of these interviews confirm a discussion in **section 3.2** where several factors that affect youth sexual life were highlighted.

7.3.2.1 Cultural Factors

The empirical study revealed that cultural inclination, especially taboos and beliefs, gender roles, and expectations are particularly influential on the perception people have for a long time that has affected the sexual life of females in general. Almost every interviewee indicated some cultural barriers for people (married or unmarried young) to access SRH services. It was observed during the FGDs, and in-depth individual interviews that gender roles are still heavily influenced by traditional norms, which tend to be patriarchal. According to the results, it was observed that women are expected to be submissive and obedient, and are not allowed to make decisions about their own SRH, including the use of contraception, and having an abortion.

7.3.2.2 Gender Inequality

According to FGD interviews, and individual interviews, it is apparent that another important social factor is **gender inequality,** which has been also discussed in section 5.3.4.3**.** The discussions with the youths had indicated that gender inequality is a major problem, with women often not having access to the same resources, opportunities, and rights as men. This therefore leads to women having less control over their own sexual and reproductive choices, thus making them more vulnerable to exploitation and abuse. Additionally, gender inequality can lead to a lack of access to SRH services and information as well as a lack of support and respect for women's sexual reproductive health rights (SRHR).

CE 1: *"We are coming from a background where the power of man over decision-making pertaining to various issues affecting women's welfare remains in the hands of men. Although there have been various campaigns grossly targeting a change of mindset on the perception of women, it seems the situation is becoming repetitive in nature".*

CM 1: *"I am an ordained minister born in the patriarchal culture. I come from a background where male dominance is very well defined. I have seen several women complaining about their husbands and that they cannot make their own decisions about their sexual lives. If anything, they make the decisions secretly without informing the husbands, for they know the outcome of that endeavour. Women cannot make decisions over their bodies. However, they are the ones at risk of maternal death. So, this culture has also affected the sexual life of the youth".*

CE 1**:** *"I must be honest with you, in our traditional customs there is a strong emphasis on traditional values and beliefs, which can lead to stigma and discrimination against those who seek sexual reproductive health services. For example, it is very difficult for unmarried young people to seek contraceptive services at any health centre, lest they are seen as immoral or promiscuous".*

Another church elder added thus:
CE 2: *"I wish to inform you that issues of ulera (contraceptives) in our culture are not only prohibited for unmarried young people, even married people are not supposed to use those methods they are regarded as harmful to people. If any are using these methods, they do it behind traditional leaders and their husbands".*

One can imagine how challenging it must be for young people to access SRH health services if married people are the ones who have such limitations in accessing such services.

FGD2: *"We know that culture is one of the key factors that has discouraged many of us young people from looking for important services including contraceptives. We were advised by our elders in our village that contraceptives are bad, and they should not be given to unmarried young people because they kill the reproductive system".*

Also, the ordained church ministers also expressed the same views on how culture has influenced SRH programmes in society.

CM 2: *"For some years now, we have ministered in most rural areas and have tried to teach people how to change some cultural practices in other areas but when it comes to issues related to sexual life, mmmmmm… it has proved to be difficult there are a lot of taboos and beliefs that requires proper approach for people to embrace flexibility. This culture has even influenced the church practices of avoiding open talks of sexual matters*".

From the the FGDs, and individual in-depth interviews; it is deducible that social, cultural, and religious factors all play an important role in shaping perceptions of SRH. This cultural influence might have also influenced the role of the church in the sexual life of people. These factors can lead to a lack of access to SRH services and information. It can also contribute to lack of support for SRH. These factors can lead to a lack of open discussion about sexual

reproductive health issues, which can further limit access to sexual reproductive health information and services. It is therefore important to address these factors to improve sexual reproductive health in Malawi.

Furthermore, the findings of the study further had confirmed that rural youths are the most affected by the culture in due course of accessing sexual and reproductive services. This finding peculiarly aligns with the findings of other researchers such as Aman et al (2017:310) who established those traditional beliefs and customs having a strong influence on sexual reproductive health, particularly in rural areas. In addition, the of this study is in agreement with the findings of Mwale et al (2018:768) who claim that in some communities, premarital sex is considered taboo, and girls who engage in it are often ostracised. This can lead to a lack of knowledge about sexual reproductive health, as well as a fear of seeking sexual reproductive health services.

Religious factors are also important in influencing perceptions of SRH. Aman et al. (2017:312) also assert that Christianity is the dominant religion in Malawi, and many Christians oppose contraception and abortion. This can lead to a lack of access to sexual reproductive health services, particularly in rural areas, where religious beliefs are stronger (Mwale et al., 2018:774). However, SRH education focuses on developing skills such as communication, decision-making, and negotiation to help young people navigate relationships, sexual activity, and other aspects of their health.

Additionally, it provides young people with the tools they need to make informed decisions about their sexual reproductive health. This includes access to accurate and up-to-date information about contraception, STIs, and pregnancy. It also helps the youths to understand their bodies, the risks and benefits associated with sexual activity, and how to make healthy decisions. It must be comprehensive and include topics such as anatomy and physiology, contraception, sexually transmitted infections, and healthy relationships to address issues related to gender identity, gender expression, and sexual orientation to provide an inclusive environment for all youth. Sexual reproductive health education should be a continuous and lifelong process.

7.3.4 Silence on the SRH of the Youth in the Synod of Livingstonia

Objective 3 of this study

The responses from the FDGs with the youth, the individual interviews with church elders, and the individual interviews with ordained church pastors from the selected congregations affirmed that there is some significant silence on SRH issues among the youth. This silence means that the churches are holding the information regarding SRH for the youths. This silence endangers the lives of the youth as they are not made aware of the safest ways of protecting their lives from SRH problems. For example, sexually transmitted diseases, unsafe abortion, and pregnancy outside marriage among the youths. The study done by Camellia et al. (2021:776) also found that most boys suffered gruesome lies and total silence from their parents, unlike girls, who expressed joy that they got all the information from their mothers concerning their menstrual and puberty developmental stages.

The results from the FGDs, and the key informant interviews all show that the church has been silent on issues of SRH as shown below.

FGD 1: *"I have been a member of this church for some years, and I do attend most of the church programmes, but I have never heard of the church talking about issues of sexual and reproductive health to us youth members. The only time I hear about sex issues is in the preaching when one preaches about sex outside marriage as a sin and punishable by God. We are not given lessons on how to manage sex pressures as young people".* The participant further noted that*, "I think the church feels that if it talks of SRH issues such as the use of contraceptives to the youth, it is promoting immorality".*

Another member from the FGD agreed with her colleague by stating that:

FGD 2: "*Our churches in most cases do share information that they think is the right one to us youth members without looking at the relevance of such information to our generation. If the church was open enough to share information like SRH, a few mistakes would have been avoided. Most young people would not be involved in early marriages, getting unwanted pregnancies, or opt to drop out of their respective schools".*

Another respondent in the focus group noted that:

FGD 1: *"What I see as a problem in our church, is we lack a forum where access to information on matters of sexual reproductive health within the church. There are so many single mothers*

out there and some have opted to start prostitution. If these female youths had access to information on SRH from the church, all the problems would have been reduced".

It is not only the youth who acknowledged the silence on SRH talk in the church; even some church elders, and ordained ministers who were interviewed also acknowledged this as presented below.

CE1: *"I believe that the church must stick to its teachings regardless of many problems the youth face. We must emphasise abstinence and faithfulness;* it is *obvious you don't expect the church to be preaching about safe abortion or use of contraceptives among the youths. The church might even lose its reputation if it does that to the youth. We know our youth today that they can access that information elsewhere but not in the church".*

Another church minister who was also interviewed also acknowledged that the church has nothing to do with SRH.

CM1*: "As an ordained church minister I feel very uncomfortable talking about sexual reproductive health to the youth in the church. I think the church can use other platforms to relay the message of sexual reproductive health to the youths. Otherwise, if the church starts engaging itself to talk about such issues it will lose its reputation".*

Taking a critical analysis from the empirical responses sampled here, it has been observed that many people are not comfortable with the sexual and reproductive health programs that are offered to the youth these days. In addition, the church's silence can also be confirmed by the lack of use of the sexual reproductive health and rights (SRHR) policy document that was developed by the Synod Health Department, and adopted by the Synod in 2016. It seems that policy has not been taken to the congregations for enforcement as indicated by most respondents in the FGDs, and from some church elders.

Most of the participants in the focus groups claimed to be ignorant of the SRH policy adopted in 2016 by Synod's Health Department. The policy was likewise mentioned only by a few ordained church ministers, who admitted that they had not read it all the way through or completely understood it.

CE1: *"Much as I acknowledge that I am a church elder who has served in different positions, I have never heard of any policy on sexual and reproductive health. Maybe it might be available in other departments of the church".*

FGD 1: *"We have been youth members for a long time but have never seen or heard about this SRHR policy. Maybe it is for the hospitals, not the church".*

CM 1: *"I have not only heard about the policy but have seen and. attended the launch of this document by the synod Moderator. However, I have not read it knowing that it won't work in our church as some contents were about contraceptives". He further observed, "I think the policy was rushed for adoption because it was a donor-funded project for the health department just to fulfil national policy requirements".*

Another church minister responded thus:

CM 2: *"Despite the Synod's health department's efforts to promote sexual reproductive health and rights among the youth, there is still a significant amount of silence in the main church (congregations). This silence is because the Synod is a religious organisation and many of its members are not comfortable discussing sexual reproductive health topics. The Synod's policy is not widely known or promoted, and many of the youth in the synod are unaware of the services that are available to them. The silence has major implications for the youth and their access to sexual reproductive health services".*

Despite the church being mute on matters of sexual reproductive health among its youth, some scholars have supported the idea that these SRH programmes are beneficial to the youth, although the raging issue remains the most controversial issue in societies and many churches, in fact, all churches. While the church remains silent on this matter, and thinks it is bad, Jacobson (2022:12) claims that this is a youthful generation caught between biology and society, between curiosity, questions, and concerns about their emerging sexual and reproductive selves and the controls, constraints, and conditions imposed by laws, policies, and community practices. Being silent on this matter is therefore not the best option. The church needs to find some ways, and vocabulary to talk about SRH constructively.

7.3.5. Reasons Why the Church is Silent on Matters of SRH

The perception is that if the church engages in promoting sexual and reproductive health services, it is directly promoting immorality among the youth. One of the key themes that emerged from the **FGD** interviews is that the church believes that if it starts supporting teenage SRH issues, it is encouraging immorality.

In the interviews, one of the church ministers emphasised that if the church starts discussing SRH issues like safe abortion, and the use of condoms, and other contraceptives, it will seem as though it was preaching immorality among the youth, which is something that is against the call of the church.

CM 1: "*In my view, the Synod of Livingstonia may fear being judged should they involve issues of sexuality in the church. Most people hold this strong belief that the church is a sacred place where faithfulness and abstinence with the assistance of the Holy Spirit are preached, and people would change automatically. But if the church takes a leading role in preaching about sexuality, I believe it can be highly judged unless it does it carefully"*.

FGD2: *"We think the church's conservativeness to its doctrines is the major reason for its silence on the issue of sexuality. Although we are talking of Synod of Livingstonia's silence, we still have not heard about other churches talking of the same".*

FGD 2: *"Although the church has chosen to be silent most of our friends in the church are being suspended because of pregnancy outside marriage. We need to ask our church to consider this problem, at school, where we hear about sexual reproductive health".*

Most of the youth who took part in the FGDs believed that the synod is not doing enough to help young people avoid unintended pregnancies and early marriages. They pointed out that the synod has not put together several events and projects to increase public awareness of the problem and to offer information, guidance, and support on it. Overall, the participants felt that the synod had not correctly approached this problem, but that something should be done to guarantee that young people are informed about the effects of early marriage, and unintended pregnancy.

Further inquiry shows that the church's silence on this matter is due to its strong emphasis on ethics as a church and because it does not want to be viewed as unsupportive of its beliefs.

They believe that as a church, they cannot support any activity that is not documented in the holy book (the Bible).

It was also found that their congregations shared information that was only applicable to a perfect human being who can practise abstinence and faithfulness. However, that information was not true to the imperfect nature of humans in the world. The information was therefore mostly considered impossible for them to reflect on since they needed to know the ways of protecting themselves from acquiring sexually transmitted diseases and unwanted pregnancies. As the church that is practising holistic ministry, called to serve; and soul, mind, and body must consider how to protect the imperfect nature of humans as they wait for grace to reach them.

The findings of the literature also support the finding of youth-parent silence, where most of the findings had established that there is a total silence, which is the case in this empirical study in the church, and similar claims were made in the findings of the studies of Kusheta et al. (2019:8), Camellia et al. (2021:775), and Chappell (2016:409).

7.3.6 Lack of Safe Spaces for Young People to Discuss and Engage in SRH

Most of the young people who participated in this focus group expressed a lack of a proper forum where the youth can discuss issues that affect their sexual health. Safe spaces provide young people with the opportunity to discuss and engage in conversations about their sexual and reproductive health (SRH) without fear of judgement or stigma. This is especially important in a religious setting such as the Synod of the CCAP Synod of Livingstonia, where discussions about sexual reproductive health can be particularly sensitive and taboo. Without a safe space to discuss these issues, young people may be reluctant to bring up topics on SRH, leaving them feeling isolated, and without the resources and support they need.

FGD 1: *" We have to be honest that every Thursday and Saturday Synod has set aside these dates for youth to meet to discuss issues that affect our spiritual life but we do not discuss anything about sexual reproductive health as this has been labelled as a secular topic that cannot be discussed in the church if the Synod can only allow this opportunity to talk to us openly they will hear what we are passing through as youth".*

What is considered secular in this perspective may also affect the spiritual part of human beings. Human beings are both spiritual and physical. To label SRH secular may not be wholly

true as the physical body can become sick due to lack of proper SRH services. It will also affect the spiritual part of humanity. So, the church must balance between the two. The church may need just to explore the right vocabulary that may suit its context when talking about SRH services rather than completely ignoring SRH services. FGD 2's excerpt on that issue is presented below.

FGD 2: *"We think apart from those regular forums where we discuss other spiritual matters, synod would have created another space or just have special topics where professionals could come and talk to us on sexual reproductive health, especially people from our health department. This will be good because most of us are ignorant of our body development".*

In agreement, some ministers who were interviewed confessed that the synod does not have proper guidance on how to discuss sex issues in the church apart from pulpit messages, and yet we always suspend young people because of pregnancy outside marriages, which is an indicator that our youth are engaged in unprotected sex activities that might expose them to STIs.

CM 1: *"When we have young people getting pregnant outside marriage, we suspend them from sacraments for some time because it is a sin and a disgrace to the Christian family. However, this is an indicator that even though we preach abstinence many youths do not follow this teaching, we really need to find another way of protecting them".*

CM 2: "What *is more disturbing is that for some when they know that they are pregnant outside marriage, they opt for unsafe abortion to avoid shaming their parents and the whole church. The lucky survive, the unfortunate ones die. I have never buried a young person who is rumoured to have died from unsuccessful abortion, so we need to re-think our practice".*

This silence can have a detrimental effect on the SRH of young people, as it can leave them without access to necessary healthcare and education about sexual reproductive health. For example, a study by the World Health Organization (WHO) found that the lack of access to SRH education was associated with an increased risk of teenage pregnancy and sexually transmitted infections (STIs) among young people in Malawi (Mwanza et al., 2018:25). This highlights the importance of providing young people with safe spaces to discuss SRH, and thereby help to reduce the risks associated with inadequate knowledge of the phenomenon.

7.3.7 Fear of Judgment

Young people may experience fear of judgement from older members of the synod when speaking about sensitive topics related to SRH. This could be due to a lack of understanding of SRH, or a fear of being judged for having opinions that differ from those of the synod. This fear of judgement could be a major factor in the presence of silence on the SRH of the youth in the Synod of the CCAP Synod of Livingstonia (Peters, 2016:178).

The fear of judgement came out many times during FGDs as quoted below.

FGD 1: *"Sadly, we hear of sexual reproductive health from the media but if we try to talk about this in church, we always fear not only our parents but even our fellow youth. We fear to be condemned as if ndiwe hule (we are prostitutes)".*

FGD 1: "*We think it will be better for the synod to create an environment where the youth could be free to talk about these sex issues otherwise many of us are suffering in silence. For example, almost every year many youths are being suspended from sacraments because of outside wedlock pregnancies. In the worst scenarios some are infected with STIs".*

FGD 2: "*Although people fear being judged because of talking about this in church, most of my fellow youth are engaged in premarital sex and they take these condoms from government hospitals. Some are even involved in unsafe abortions. We know some ladies who have died from unsafe abortion complications, but people can't talk about it openly for fear of being judged".*

CE 1: ***"****I understand that the church has a holistic approach in serving its members. I wonder why the synod is not deviating away from its approach in rendering the services to the members".*

The fear of judgement from older members of the Synod can have a detrimental effect on the willingness of young people to speak up about sensitive topics related to sexual reproductive health. This fear of judgement can lead to an environment of silence, where topics related to sexual and reproductive health remain unspoken and unaddressed. This is not only detrimental to the health of the youth, but also to their overall educational and social development (Mann,

2017:933). Moreover, it can create a culture of silence and stigma surrounding sexual reproductive health, which in turn can lead to a lack of access to sexual reproductive health information and services for youth (Kerrigan, 2016:10). It is therefore essential that the CCAP Synod of Livingstonia works to create an environment of acceptance and understanding, free of judgement, where young people feel safe to discuss SRH topics openly.

7.3.8 Misconception

The findings from both focus group discussions and individual interviews from different categories of people have different perceptions of divulging SRH information. From the analysis, it is apparent that most people feel that the church cannot engage in directly telling youth about SRH, because, by doing so, most people misconceive that the church will divert from its noble calling of changing the spiritual life of Christians. One respondent noted:

CE1: "*I am of the view that the church should not be preaching about sexual and reproductive issues. Rather, it should leave the issue to other organisations because this is a secular issue".*

This shared misconception leaves the church in a perplexed position as to whether or not to engage in preaching about sexual and reproductive. Furthermore, engaging parents to talk to their children about sexual and reproductive messages, means they are also promoting sexual immorality among their children.

It is deducible that there is a significant amount of silence on the SRH of the youth in the Synod of the CCAP Synod of Livingstonia. This silence is because the synod is a religious organisation and many of its members are not comfortable discussing sexual reproductive health topics. Additionally, the synod's SRH programme is not widely known or promoted, and many of the youth in the synod are unaware of the services that are available to them. Furthermore, synod's SRH programme is not adequately funded or staffed, which further limits its ability to provide comprehensive SRH services to the youth.

7.4. Theological Grounds for Speaking Out on the SRH of the Youth by the Synod of Livingstonia

Objective 4 of this study

This discussion explores the practical theological grounds for speaking out on the SRH of the youth. The role of practical theology is to analyse the realities in real life situation. The main theological ground should be based on the concept of the Image of God Imago Dei focusing on human dignity. This theological concept focuses on the inviolability of human beings, and the equality of all human beings before God regardless of gender age, and status or age. Every human was created in the image of God. Although the respondents to this interview were without proper theological knowledge of how theology is interpreted when asked what could be done, some were able to mention some ethical issues that might be theologically related to human dignity.

SRH issues such as maternal death due to unsafe abortion, unwanted pregnancy that may result in forced marriage, contracting STIs due to unprotected sex, early school dropout due to unwanted pregnancy, and many more arise because of poor SRH services. All the aforesaid consequences of lack of sexual reproductive health may be attributed to a violation of human dignity. Should the church remain silent in such situations the church may be guilty of indirect support of this violence to human beings. So, the synod must find a way to maintain the inviolability of human dignity. Some church ministers who were interviewed had to make the following observations proposing that the church should take advantage of its mission statement which calls for a holistic approach for its ministry. Similarly, the church is called not only to save the spiritual part of human beings but also their physical needs. What does it benefit the church if most of the youth are dying physically because of STIs due to failure to access SRH services?

CM:2 "*The holistic nature of the church that is called to save both spiritual and physical life of people purports that the Synod of Livingstonia support programs for the Sexual Reproductive Health of the youth may be grounded in its theological understanding of the human person. The synod believes that all people are created in the image of God and are therefore deserving of respect and dignity. This includes the right to make informed decisions about their own sexual reproductive health. The synod also believes that the church has a responsibility to provide guidance and support to young people in matters of sexual reproductive health. This includes providing accurate information about sexual reproductive health, advocating for access to sexual reproductive health services, and supporting young people in making informed decisions about their sexual reproductive health. What is needed is just to find a proper way of doing it".*

CM 2: *"The church is responsible for building the spiritual and physical lives of many church members. One of the holistic ways of growing the church members is to ensure that the physical life of its members is attended to. However, it is surprising that the church regards counselling youth about their sexual life as a sin. This is very much in contrast to its noble call of building the physical life of church members, especially the youths who are usually regarded as the future leaders of a country".*

The Synod of Livingstonia is a church organisation in Malawi that is committed to the spiritual and physical well-being of its members[18]. There should be a significant shift from the traditional stance of the church, which has historically been silent on issues of SRH.

The synod has always emphasised that the church ought to provide a haven of solace and consolation for those who are suffering. Supporting and advising young people on issues related to sexual and reproductive health is part of this. The synod's advocacy for the sexual and reproductive health of the young people in its flock has not gained more cloud in recent years regardless of having developed SRHR policy for youth in 2016. Its dedication to the overall well-being of its members has been heavily credited with this change in position. The synod is however still very silent on such matters despite its declarations on various platforms.

This perception follows Hall et al.'s (2012:740) suggestion that religious institutions may be associated with an increased risk of stigma and shame among young people engaging in SHR practices, due to the potential for conservative religious views to be enforced on young people in the name of SRH. Furthermore, research by Fentahun et al. (2012) suggests that religious institutions may be more likely to encourage abstinence-only sexual reproductive health education, rather than providing access to sexual reproductive health services and a comprehensive understanding of sexual reproductive health. Therefore, it is important to consider the potential for unintended negative impact when discussing the Synod of Livingstonia's support for the SRH of the youth.

The synod's support for the SRH of the youth is also grounded in its commitment to social justice. The synod believes that all people should have access to sexual reproductive health

[18] Mission statement of Synod of Livingstonia

services and information, regardless of their gender, age, or socio-economic status. The synod also believes that the church has a responsibility to advocate for the rights of young people in matters of sexual reproductive health.

This includes advocating for access to sexual reproductive health services, advocating for the rights of young people to make informed decisions about their SRH, and advocating for the rights of young people to access SRH services without fear of discrimination or stigma. This statement on the synod's support for the sexual and reproductive health of the youth is commendable. It is however important to note that there are still numerous challenges facing young people in terms of accessing SRH services, and information in many parts of the world.

For example, a study by the United Nations Population Fund (UNFPA, 2017:4) found that in developing countries, young people often face a range of barriers to accessing SRH services, including a lack of knowledge on SRH, gender inequalities, cultural and religious taboos, and cost. Additionally, young people may face stigma and discrimination such as being judged for their sexual behaviours when attempting to access SRH services. These challenges must be addressed for young people to have true access to SRH services, and information.

Finally, the Synod of Livingstonia's support for the SRH of the youth is grounded in its theological understanding of human dignity and its commitment to social justice. The synod believes that all people are created in the image of God and are therefore deserving of respect and dignity. The synod also believes that the church has a responsibility to provide guidance and support to young people in matters of SRH, and to advocate for the rights of young people in matters of SRH. By speaking out on the SRH of the youth in and by the Synod of Livingstonia, the synod is demonstrating its commitment to the holistic well-being of its members.

7.5 Conclusion

This chapter presented the findings and discussion of the qualitative empirical data collection that took place in the CCAP synod of Livingstonia. The data was in the attempt to address the five objectives of this study to answer the research question of this study. The findings of this study through thematic data analysis were summarised into five themes, explaining the definition of SRH, and how people value the importance of sexual reproductive health, the misconception of SRH, barriers to teaching SRH among the youth in the church, theological

basis for the church to engage on SRH among the youth, and finally proposed strategies that the church can adopt to address the SRH among the youth.

Finally, the points discussed have examined the need for the Synod of Livingstonia to address the SRH needs of its youth and have suggested practical ways in which the Synod of Livingstonia via its youth ministry may break the silence on the SRH of the youth in the Synod of Livingstonia. The synod must address the SRH needs of its youth, as this is essential for their holistic well-being. The outlined suggested measures if implemented, may prove to be beneficial in allowing the synod to adequately address the SRH needs of its youth. It is also equally important to consider potential obstacles and to draw on the work of other researchers to gain a deeper understanding of the SRH needs of the youth in the Synod of Livingstonia.

CHAPTER 8

CONCLUSION AND RECOMMENDATIONS

8.1 Introduction

This chapter presents the conclusion and recommendations of the findings of this study to the Synod of Livingstonia. The empirical study focused on the five objectives as discussed in chapter seven of this research to answer the research question of this study.

8.2 Summary of Key Findings

This section highlights the knowledge and importance of SRH among the church respondents, and further assesses the role of culture on sexual reproductive health as discussed in chapter 7. The chapter further examined the silence and role of the church on SRH, and finally discussed the possible theological grounds for the church to break the silence on sexual reproductive health.

8.2.1 Knowledge and Importance of Sexual Reproductive Health

It was found that all interviewees, church elders, ordained church ministers, and the youth were aware of the SRH programs, and they all appreciated the importance of SRH **(7.3).** The findings further confirmed that SRH programmes can mitigate early marriages, and unwanted pregnancies and can control the spread of STIs among young people. The findings further confirmed that the youth get information on SRH from both print and electronic media. The youth added that they usually get the information from peers and school curricula apart from media sources.

The findings further showed that out of all the services within the SRH package, abortion was mentoned as being more sensitive in the discussion as it was demonised by most respondents. However, some ministers and elders were quick to admit that though abortion remains a sin on some special occasions, and acceptable for married women upon the approval by a medical doctor.

The respondents also admitted that unsafe abortions are mostly done secretly, and some people are dying without being mentioned in public for fear of both church discrimination and prosecution from the government since abortion is still illegal in Malawi.

The findings had also established that some respondents expressed concern over the conservativeness of church policies that had failed to allow the youth to access SRH services. On this, some were quick to say SRH services may be improved in the church with the change of policies that may be able to accommodate SRH programmes for the sake of the good health of the young people.

8.2.2. Cultural Influence on Sexual Reproductive Health

The findings established that some of the cultural factors such as beliefs and taboos, gender roles, and silence on matters of sexual life between parents and children contribute to the lack of SRH among the youth (see section 7.4.1). It was found through the interviews that if SRH is composed of contraceptives, safe sex, and safe abortion has no room for discussion in this culture.

The main concern was the perception that promiscuity would be rife should the youth be exposed to contraceptives. Another perception was that married women are not supposed to be using contraceptives due to the belief that it destroys fertility among women. In addition, gender roles also contribute to the negative effect of SRH services since even married women cannot access SRH services without the consent of their husbands. This means women have no right to make decisions over their bodies.

The findings further showed that because of these taboos and beliefs, other cultural-related beliefs have contributed to the negative effects of SRH services mainly in rural areas. Lack of SRH services will increase problems like early marriages, unwanted pregnancies, and school dropouts in the worst circumstances may increase maternal death due to unsafe abortions.
Lack of openness between parents and children in matters of SRH may also negatively affect the sexual health of young people, and increase health risks for young people. Most of the respondents indicated a practical review of some customs.

8.2.3 Silence of Church on Sexual Reproductive Health

The findings from the data collected from focus group discussions and individual in-depth interviews showed that a significant silence on matters of SRH was found in Synod of Livingstonia. This means that the church is indirectly holding important information that endangers the sexual health of the youth. According to the findings, several reasons are influencing the church to be silent as observed below.

8.2.3.1 Misconception

The findings from both FGDs, and individual interviews clearly indicated that most people feel that the church cannot engage in directly telling youth about SRH, because, by doing so, most people misconceive that the church will divert from its noble calling of changing the spiritual life of Christians. In other words, the church will be compromising its calling. The shared misconception has not only affected church forums but also members of the church who cannot talk of SRH with their children because they may look like they are promoting sexual immorality. Another misconception noted during this was that the issues of SRH are secular and must be dealt with by secular organisations, not Ecclesia. It was also identified that this misconception has contributed to the lack of promoting SRHR policy that was developed in 2016 by the Synod Health Department. The findings further observed that this silence may expose the young to many risks that come because of lack of SRH services.

8.2.3.2. Fear of Judgment

The findings noted the fear of judgement from older members, and even fellow young people of the synod when speaking about sensitive topics related to SRH **(**see section 7.5.3**).** Another fear was being judged for having opinions that differ from the policies of the synod. It means that those who appreciate the importance of SRH fail to talk openly fearing to be considered immoral people. Many parents also feared to talk to their children because they would be considered as being weak Christians by their children. This fear may also result in creating a spirit of stigma among the youth while denying them access to relevant information for SRH.

8.2.3.3 Lack of Safe Space for Young People to Discuss and Engage in SRH Issues

The findings indicated that most of the young people who participated in this focus group expressed a lack of a proper forum where youth can discuss issues that affect their sexual health life (see section 7.5.2). This implies that safe spaces provide young people with the opportunity

to discuss and engage in conversations about their SRH without fear of judgement or stigma. This is especially important in a religious setting, such as "the Synod of the CCAP Synod of Livingstonia", where discussions about SRH can be particularly considered sinful. Without a safe space to discuss these issues, young people may be reluctant to bring up topics of SRH, thus leaving them with isolated feeling, and without the resources and support they need. There is a need therefore for the synod to create such an environment.

8.4 Recommendations

By referring to the findings of this empirical study, these recommendations are directed at the CCAP Synod of Livingstonia where this research was conducted. It is my sincere hope that synod will take this opportunity to look at SRH as a theological challenge and opportunity for youth ministry. Furthermore, it must look at SRH beyond spiritual life. All recommendations made in this study focus on breaking the silence of SRH under the framework of Practical Theology while focusing on theories of youth ministry. The recommendations also consider ethical issues, holistic ministry, the theological concepts of human dignity, the inviolability of human beings, gender roles, and rights issues. The recommendations will, however, not compromise the spiritual component of the church but may explore the applicable theological vocabulary. This recommendation can also be used by the entire faith community that may not have an opportunity to promote SRH programs.

8.4.1 Engagement of Practical Theological framework

Almost all recommendations to this study will be within the Practical theological framework. Practical Theology apart from the study of church is an interdisciplinary field of study. Practical Theology works among other disciplines. According to Miller-McLemore and Mercer (2016:1), being an interdisciplinary study practical theology plays an important role in academia as it connects the church and society. The aim of Practical Theology is to put beliefs of the church into action and scientific explanation to normative appraisal. The role of Practical Theology is to analyse the realities in real life situation by bringing social -theological transformation (Mercer, 2014: 436).

Matters of SRH are very important to be analysed and discussed theologically as it affects the life of human beings. This study adopted Osmer's method of interdisciplinary approach because of the need to theologising issues of SRH from a place of violation of the dignity and sexual rights of the youth. The church is called to address the needs of human beings holistically rather than focusing on spiritual

part only. De Gruchy (2003:20) notes that, “just as the body without spirit is dead, so faith without works is also dead.” James 2:26.

Inviolability of Human Being

Chapter 5 discussed the attributes of God that are passed on to human beings after created in the image of God and one of them is the inviolability of humanity. Findings of both literature review and empirical study indicated that lack of SRH services are unwanted pregnant, unsafe abortion, contraction of STI’s, early marriages, and school dropouts. Therefore, if the church denies youth access to SRH services, either by not giving them information or by condemning those accessing SRH information that will result into the above consequences, the church may be directly or indirectly contributing to these effects.

Consequences of lack of SRH were theogically interpreted as a violation of human dignity. For instance, if one is not given information on safe sex will end up contracting STIs that will affect his/her general welfare may be considered violation of right to information. If one is engaged into unsafe abortion in fear of church suspension, and dies is interpreted as a violation of human diginity. If one gets unwanted pregnant and drop out from school may not be able to contribute meaningfully to the socio-economic development of the family and the nation hence creating a vicious circle of poverty that is interpreted as a violation of human dignity.

While the church is doing its good job of preaching abstinence, and preparing people to live an upright moral life; it has to equally consider the fact that sex is secular and a biological part of human growth. The church has also to believe that there is a thin line between human dignity, and human rights. Within the human rights, there is also sex rights as observed in *chapter 5*. Furthermore, findings of empirical conducted also indicated that the church has perpetrated the suspension of young people pregnant outside wedlock, and the worst findings enough were of those who died on the allegation of unsafe abortion.

Gender Justice

Amongst the young people involved girls are the most victims of such decisions. For instance, when it comes to suspension from the church because of unwanted pregnancy it is the girl, the one who dies of unsafe abortion is a girl, the one engaged in forced marriage because of unwanted pregnancy is a girl. The discussion in chapter 5 also talked about gender injustice, an equal treatment between men and women yet they are both created in the image of God and bears that inviolability attribute of God.

Therefore, looking at above theological arguments about human dignity in chapter five in line with the findings of empirical study the church must be mindful that sex is biological and spiritual matter, and the binary understanding of being human should be addressed. This study recommends to the church to review its theological stand on issues of SRH among other recommendations below.

a) Engage and orient church elders on the importance of SRH

The Synod of Livingstonia should engage with faith leaders in the synod to ensure that they are supportive of sexual reproductive health and youth rights. This can include providing them with information and resources on SRH, as well as engaging in dialogue on how to best support the youth on sexual reproductive health matters without compromising their biblical faith. It was suggested in the FGD interviews that the Synod of Livingstonia should engage with faith leaders to ensure support for SRH, and youth rights. There are however potential risks to this approach. For example, some faith leaders may be resistant to this dialogue, as they may view it as an encroachment on their moral authority. Additionally, this approach may result in a polarisation of the community, as some faith leaders may become more entrenched in their beliefs and draw their followers with them. Such a situation could have long-term negative implications for the synod's work on sexual reproductive health and youth rights.

Therefore, while engaging with faith leaders is one approach to supporting SRH, and youth rights in the Synod of Livingstonia; it is crucial to also consider other strategies that may be more successful in obtaining community-wide support. For example, interventions that focus on education, dialogue, and collaboration between community members and leaders may be more effective in creating a culture of acceptance. Such an approach may help to ensure that all stakeholders, including faith leaders, have a voice in promoting SRH, and youth rights.

b) Develop a Theological Sexual Reproductive Health -Informed Resources

The Synod of Livingstonia should create theological SRH-informed resources such as handbooks that church ministers and elders may use when discussing with young people about SRH issues without diluting their biblical faith. The ***synod has a literature department*** that can easily produce such resource materials.

Furthermore, synod must also develop pamphlets and handouts that the youth can access to learn more about SRH in a Christian manner. These resources should include accurate and up-to-date information about SRH, and they should be accessible in multiple languages.

This may be difficult to ensure that the information provided is accurate and up to date. Additionally, creating resources in multiple languages may be a huge task and require considerable resources from the Synod of Livingstonia. Some respondents alluded that providing health education is not always successful in improving health outcomes. Meanwhile, it may be important to consider other strategies to ensure the effectiveness of SRH-informed resources. Furthermore, it is important to consider any potential negative consequences such as increased stigma that may arise from providing SRH-informed resources. It is important to ensure that the resources are created and distributed ethically.

c) Implement a Sexual Reproductive Health Educational Programme in the Church

The Synod of Livingstonia's youth ministry should consider implementing a SRH educational programme for the youth in its jurisdiction. This program should include a comprehensive curriculum that covers topics such as SRH, human rights, gender advocacy, HIV/AIDS prevention, and treatment, contraception, and sexual violence prevention.

The programme should also provide sexual reproductive health counselling and support services, as well as resources for young people to access further information and support. The programme needs to also emphasise the importance of seeking professional help when needed. Moreover, the programme should involve parents and other influential adults in the community to ensure that young people receive accurate information and support in a safe and comfortable environment (Kirby, 2018:10).

This education should be provided in a safe and non-judgmental environment to ensure that young people feel comfortable engaging with the topic and asking questions. However, some potential negative consequences should be taken into consideration. For example, some young people may feel embarrassed discussing sexual reproductive health topics in front of their peers and parents, and the discussion of such topics may lead to stigma, shame, and discrimination.

Moreover, some parents may be resistant to the idea of such an educational program and may even try to prevent their children from participating in it. Additionally, there is a risk that the

information provided may not be accurate or up to date, leading to incorrect or incomplete information being disseminated. Furthermore, Zhang et al. (2020:14) pinpoint that SRH education should focus not only on the physical aspects of sexuality, but also on the emotional, social, and spiritual aspects, to ensure that young people are receiving a comprehensive education on the topic. The programme must therefore include a holistic approach to SRH education.

d) Establish Youth-friendly Health Centres in Presbyteries

To break the silence on SRH among the youth in the Synod of Livingstonia, the SRH interview analysis suggests that the youth ministry should consider establishing youth-friendly health centres in the presbyteries. These centers should provide youth-friendly services that are tailored to the needs of Christian young people in specific areas including sexual reproductive health counselling, contraception services, HIV/AIDS prevention and treatment, and sexual violence prevention. These centres should also ensure that their staff members are qualified and experienced in providing sexual reproductive health services and that the centres are equipped with the necessary supplies, and equipment.

The synod must take advantage of the existing structures such as the ***Livingstonia Synod Aids Programme*** (LISAP). The department was established to address issues of HIV/AIDS and other related health issues. The synod may use the expertise they have with properly identified church vocabulary. The synod has also the Synod Health Department that champions health issues. The health department may also help to interpret the SRHR policy that was adopted in 2016. While establishing youth-friendly health centres in the Synod of Livingstonia is an important step in breaking the silence on SRH among the youth, it is important to consider the potential negative impacts of such an endeavour. For instance, there is the potential for increased stigma and discrimination in the area as well as the potential for reduced access to care due to cultural and economic barriers. Additionally, the results from key informant interviews, and FGDs had revealed that it is important to consider the challenges of developing appropriate sexual reproductive health services for young people in the area, including the need for comprehensive and age-appropriate training for staff members.

Finally, there is a need for further research on the effectiveness of youth-friendly health centres in similar contexts, to ensure that the initiative is successful and sustainable.

e) Identify and Train Youth Advocates

The Synod of Livingstonia, through youth ministry, must advocate for the rights of young people to access SRH information and services. This could involve raising awareness of the rights of young people to access SRH information, and services; and advocating for relevant laws and policies that guarantee young people's access to SRH information, and services (UNFPA, 2020:10). This could be another way of breaking the silence on SRH while advancing the youth ministry.

The synod must use the existing structure of the ***Church and Society Department***. The Church and Society is a synod department that was established to deal with human rights issues in the country. The department has trained people who can work hand-in-hand with church elders, and ministers on how they can ethically consider the role of the church on SRH issues.

The Synod of Livingstonia should also train youth advocates who can provide SRH-related education, and guidance to other youth. These advocates should be knowledgeable on SRH, and should be able to provide accurate, and up-to-date information to their peers. This could be a commendable initiative by the Synod of Livingstonia to advocate for the rights of young people to access SRH information and services.

Importantly, training youth advocates are to provide SRH-related education, and guidance to other youth is a great way to ensure that young people have access to accurate and up-to-date information. However, some potential negative impacts should be noted. First, it is important to ensure that the information being disseminated is accurate, and up to date. It is also crucial to ensure that youth advocates are adequately trained, and supported.

Research conducted by the Guttmacher Institute found that programmes that fail to adequately train, and support youth advocates are more likely to have negative outcomes such as reduced access to SRH services and reduced use of contraception (Zhang et al., 2020:11). Secondly, it is crucial to consider the potential social and cultural implications of training youth advocates to provide sexual reproductive health -related education, and guidance.

Research conducted by the Population Council in India found that while some communities welcomed the increased availability of SRH information, other communities were more resistant to such initiatives due to cultural and religious norms (Mathew et al., 2019:550).

Thirdly, it is important to consider the potential for youth advocates to become a target of discrimination or stigma due to their involvement in sexual reproductive health-related activities. Another study by WHO likewise established that youth advocates are often stigmatised due to their involvement in SRH-related activities, which can lead to reduced access to sexual reproductive health services and reduced use of contraception (Kirby et al., 2017:26).

Therefore, while training youth advocates to provide SRH-related education, and guidance is a commendable initiative, it is pertinent to consider the potential negative impacts, and take steps to mitigate them.

f) Synod must Organise Seminars and Workshops

The Synod of Livingstonia must organise regular seminars and workshops to engage with the youth to discuss the importance of SRH. During these sessions, youth should be provided with relevant information about SRH, be encouraged to ask questions, and be provided with a safe space to share their stories and experiences (Gómez-Espín, 2019:2).

In as much as that is the case, there are a few potential challenges that should be taken into consideration. It was observed in the interviews that some of the youth may not be able to attend seminars, and workshops due to transportation or scheduling conflicts. Additionally, there may be cultural or religious stigmas around sexual reproductive health that could lead to a lack of engagement and participation. If these issues are not addressed in an effective manner, the seminars, and workshops may be unsuccessful. Furthermore, the Synod of Livingstonia needs to work with other stakeholders such as health workers, and local media outlets in the community to ensure that the message of SRH is spread effectively. While seminars, and workshops can be beneficial, they should not be the only means of engagement and should be supplemented with other tactics to ensure maximum effectiveness.

f) *Organize Workshops and Seminars for Community/ Traditional Leaders*

Synod must make deliberate programmes that occasionally should invite community/traditional leaders who are custodians of culture to engage them on issues of SRH. The main aim of these workshops would be to discuss with elders how to eliminate some cultural barriers to SRH services for young people as well as gender role issues that, at times, oppress women, especially in this patriarchal culture. Traditional leaders and faith leaders have the same role in leading and guiding people in communities. At times the church may also need to involve health practitioners to give some health tips during such meetings.

During these seminars, the focus would be on how culture may help to provide good sexual health among the youth rather than focusing on customs that are detrimental to human health. Social cultural practices, and religious practices are all concerned with human life. The church must therefore capitalise on this to break the silence of SRH.

g) *Incorporate Sexual Reproductive Health into Existing Programming*

The Synod of Livingstonia should consider incorporating SRH into existing youth-centred programming such as youth camps and retreats. This can include providing educational sessions on SRH, thus hosting support groups, and creating safe spaces for youth to discuss SRH issues.

The proposal to incorporate SRH into existing youth-centred programming is an important one, as it can provide the youth with access to important information and support. However, it is important to consider the potential negative implications of such a proposal. For instance, introducing SRH topics into youth-centred programming could potentially create feelings of shame or stigma among youth. Additionally, the Synod of Livingstonia should consider the challenges of implementing SRH programming within existing youth-centred programming such as a lack of funding, limited access to trained professionals, and limited resources for youth to access during and after the programming.

It is also important to consider the effects of such programming on youth from different backgrounds. For example, youth from vulnerable populations may be less likely to access SRH programming due to culture and language. By considering these potential issues, the Synod of Livingstonia can ensure that itsSRH programming is effective and beneficial for all youth involved.

h) Connect Youth with Trained Professionals

The Synod of Livingstonia should connect youth with trained professionals who are knowledgeable about SRH. The synod may wish to take advantage of their employees in the mission hospitals. This could be done through the creation of a referral system where youth could access information about trained professionals in their area. Additionally, the Synod of Livingstonia could organise sessions with professionals who could provide advice and guidance about sexual reproductive health to the youth.

There are, however, a few potential drawbacks that should be considered. First, the youth may not find these services accessible due to cost, stigma, or lack of access to transportation. Additionally, research by Edeh and Abu (2016:706) reported that providing youth with access to trained professionals does not necessarily guarantee that they will use the services. The authors suggest that a comprehensive health system that is adapted to the needs of the local population is needed to ensure the successful implementation of the referral system.

There is also a need for further research to assess the effectiveness of such a system. Further research should include a comparison of the services provided by trained professionals, and those provided by untrained professionals as well as an evaluation of the impact of the referral system on the health outcomes of youth. By incorporating such research into the referral system, the Synod of Livingstonia can ensure that youth are receiving the best possible care and guidance.

i) Peer Education Programmes in the Youth Programmes

The Synod of Livingstonia's youth ministry should also consider providing peer education programs to break the silence on SRH among the youth in the area. The synod may take advantage of the Synod of Livingstonia Education department to work hand-in-hand with congregations. These programmes should involve young people in the area who are knowledgeable about SRH topics, and are willing to share their knowledge with other young people.

These programmes should also ensure that the peer educators are properly trained in SRH topics, and that they have access to the necessary resources and support to effectively carry out their work (Kirby, 2018:11). Nonetheless, there are a few potential drawbacks that should be taken into consideration. For instance, while these programs may be successful in creating a safe space for young people to learn and discuss SRH topics, there is a risk that the peer educators could be seen as a source of judgement or authority, rather than a knowledgeable and supportive friend. In addition, if the peer educators are not properly trained in sexual reproductive health topics, they may disseminate inaccurate information that could lead to further confusion or negative health outcomes (Elliott et al., 2019:54). Furthermore, there is a need to ensure that the young people themselves are willing to participate in and engage with the programme. Otherwise, the programme may fail to achieve its desired outcomes (Kirby,

2018:12). Overall, this proposal has the potential to be an effective solution for addressing the silence on SRH among the youth in the area. Nevertheless, it is essential to consider the potential drawbacks of the programme, and to develop strategies for mitigating them.

j) Develop Sexual Reproductive Health Awareness Campaigns

The Synod of Livingstonia's youth ministry should consider breaking the silence on SRH by organising awareness campaigns. These campaigns should focus on raising awareness about the importance of SRH and the consequences of lack of SRH. The awareness must further provide young people with accurate information about SRH topics such as contraception, HIV/AIDS prevention and treatment, and sexual violence prevention.

The campaigns should also emphasise the theological importance of valuing the human dignity of every human being who is created in the image of God (imago dei). The awareness must further consider Christian ethics. Ethics must be applied to all human beings regardless of their spiritual stand in faith. The awareness, and approach on how to assist those who may not be able to abstain. However, it must also be noted that such campaigns should also consider the potential for backlash from certain groups in the community as well as the potential for such campaigns to be misinterpreted, or taken out of context.

Additionally, while it is important to provide accurate information about sexual reproductive health topics such as contraception, HIV/AIDS prevention and treatment, and sexual violence prevention, it is equally important to ensure that the language used in such campaigns is gender-inclusive, age-appropriate, and culturally sensitive. Finally, any campaigns developed should be accompanied by ongoing support and resources for young people to ensure that their SRH needs are adequately addressed.

k) Partner with local organizations

The Synod of Livingstonia, via its youth ministry, should also partner with local organisations that are dedicated to promoting the SRH of the youth. These organisations can provide the Synod of Livingstonia with the resources and expertise it needs to effectively break the silence on the SRH of the youth (Kiragu et al., 2019:4). Partnering with other organisations would be very important since SRH is a multidisciplinary phenomenon that requires different stakeholders to promote SRH services.

The Synod of Livingstonia should host youth-led events such as conferences, summits, and rallies, to create awareness about sexual reproductive health among the youth. This could be done in partnership with other organisations such as local schools or community centres. However, there are a few potential challenges that should be addressed. For example, it is important to consider the resources available to the Synod of Livingstonia, and local organisations for these events. If there is a lack of financial resources, or organisational capacity, it may be difficult to effectively implement this suggestion. Additionally, it is important to consider the potential for stigma and discrimination toward youth who are engaging in SRH activities. It is essential to equally create a safe and supportive environment for youth to openly discuss their SRH needs and experiences without fear of judgement or repercussions.

Finally, it is important to consider other research in the area and to build on existing interventions and initiatives. Furthermore, it was observed in the interviews that involving religious leaders in SRH education can help to reduce stigma and increase acceptance of SRH among the youth. This could be a useful strategy for the Synod of Livingstonia to consider.

l) Explore How to Utilise Social Media Platforms

The Synod of Livingstonia has its own radio station known as Voice of Livingstonia (VoL), which the church can use to disseminate SRH information. It can also use other social media platforms such as Instagram, X, WhatsApp groups, and Facebook to create awareness about SRH among the youth. This may be more effective since the modern youth are deep into social media platforms. The Synod Youth Ministry may likewise create a page where young people may access information and ask questions.

This will help those who may be shy to discuss with others in person in the above-suggested forums. This can be done through the creation of campaigns, informative posts, and infographics that detail key information about SRH.

Additionally, the Synod of Livingstonia should use social media to interact with the youth and create a safe, virtual space for important conversations about SRH (Lakshmi & Desai, 2018:846). Meanwhile, there are some potential drawbacks to consider. For example, the youth may be exposed to false information or manipulated content related to SRH due to the lack of

control over the content posted by users (Nabi & Prestin, 2017:19). Moreover, there is also the risk of cyberbullying, harassment, and other negative interactions on social media (Razmus, 2019:58). The Synod of Livingstonia must develop a safe and secure virtual space for the youth to engage in conversations about sexual reproductive health.

m) Develop a Community-based Approach to SRH-related Issues

The synod through youth ministry should create a community-based approach to SRH-related issues to ensure that the youth have access to accurate information and resources. It was further suggested in the interviews that the synod should be encouraged to work with local health facilities and health care providers to ensure that all youth have access to quality health care services. Nevertheless, it may not be enough to ensure that all youth have access to accurate information and resources. This is because not all local health facilities and healthcare providers are equal in terms of quality and resources Furthermore, there is a need to consider the intersectional factors that may impede access to healthcare services such as gender, race, income, and disability. Moreover, it is important to consider the existing power dynamics that may prevent youth from accessing adequate healthcare services. It is therefore important to incorporate a comprehensive approach that considers these power dynamics and intersecting identities to ensure that all youth have access to accurate information and resources.

n) Monitoring and Evaluating Programmes

The Synod of Livingstonia should monitor and evaluate their efforts to break the silence on SRH. This can include conducting surveys, interviewing youth and stakeholders, and tracking progress on SRH-related initiatives. It would be however beneficial to also include potential negative outcomes that could arise from the synod's efforts. For example, it could be useful to consider how the implementation of SRH-related initiatives could affect the local community, and how that could be monitored and evaluated. Furthermore, it would be useful to discuss how the synod should respond to any negative outcomes that are uncovered. By accounting for potential negative outcomes, the synod can be better prepared to address them and make any necessary changes to its efforts.

o) Work with other Christian mother bodies

The Synod of Livingstonia is affiliated to many Christian mother bodies in the country. It is therefore recommended that the synod youth ministry should network with those ecumenical bodies. The problem of silence may not be only in the CCAP Synod of Livingstonia. Working with others may also help synod to mitigate some harmful cultural practices that negatively affect SRH programs in the country. For example, the synod may wish to work with the Malawi Council of Churches (MCC), the Evangelical Association of Malawi (EAM), the Episcopal Conference of Malawi (ECM), the CCAP General Assembly, and many others.

p) Practical Theological Approach

The church will explore biblical and theological strategies to address the sexual health challenges faced by youth by focusing on the value of human beings. The church will need to make policies that will address the needs of human beings holistically by making programmes that will address not only spiritual needs, but also physical and social needs such sexual challenges.

8.4.3 Contributions to the Academic Corpus

This research has potential to contribute greatly to the body of knowledge on SRH as it challenges the faith community to look at SRH issues with an ethical and theological lens. The research has not only challenged the faith community but also the cultural practices that require a review. The research findings are also capable of providing other researchers with resource reference when conducting further research on the same or similar topics. Once it is published, this thesis will be found in different libraries and online sources by future researchers.

This research, focusing on SRH is the first of its kind to be conducted in the Synod of Livingstonia. This will provide a platform for the church to open academic or spiritual debates. It is out of these debates that the church may find a better ground to review some of its doctrines. This research may be used by other churches and Christian mother bodies in the country. This research is also capable of opening churches' eyes on how to balance spiritual matters, and ethical issues. The research findings are very practical rather than theoretical based.

Firstly, this study has added to resource materials on the subject matter for further studies on the same topic or related ones. This research has therefore challenged practical theological researchers and youth ministry workers on how they can theologically handle social issues that affect young people in the real-life situation. The study further challenged the youth ministry workers to explore on how they can practically relate Practical Theology as an interdisciplinary

study can relate with Christian ethics in the context of SRH as both a spiritual, and biological challenge.

This study has provided an opportunity for Practical Theology and youth ministry workers to develop a theology that will consistently engage in dialogue between seminaries, and theological colleges, and churches as practitioners or implementors. The main goal of the dialogue is to facilitate a theology of youth that is relevant to young people's concern of realities that confronts their spiritual, and social life challenges.

The study has contributed to a possible hermeneutical approach of theological concept of human dignity in relation to the attributes of the Image of God Image dei, and SRH among the youth. The study also added to strategies through which human rights issues can be theological interpreted by conservative churches.

Youth ministry may be understood as the engagement of youth with scriptures to shape their lifestyle in theological context. According to Ward (1995: 25), youth ministry theology seeks to express how God can shape and influence the Christian life of a youth. Youth ministry requires inquiry to find out the best way to address the challenges faced by the youth. In other words, youth ministry is a missiological task.

The best way to implement youth ministry work is to first note or study youth culture. Mostly, youth culture is characterized by music, code of dressing, and their interests (Borgan, 1997:29). What is required is to engage theology of incarnation or enculturate the gospel. In other words, youth ministry has to be contextualized into subculture of youth through the incarnational commitments (Borgan, 1997:29). We must live with youth, and listen to their stories. Doing the above will lead us to understand youth subculture. Erwin (2015:53) explains that, "subculture forms when groups have difficulties achieving status within the normal, legitimate avenues of a dominant culture? Groups that are marginalized in a society (for example, working class, poor minority populations, women, and so on) find solutions to the problems of their marginalization resulting in a cultural practice that are "distinct from the larger culture but borrow and often distort, exaggerate, or invent its symbols, values, and beliefs".

Borrowing the same understanding of how subculture is developed, youth ministry workers must consider that youths can also develop their own subculture deviating from larger culture. Long before a young person begins the transition from childhood to adulthood, the adolescent has had a long experience in the culture of his or her family. However, the development changes along with web of relationships in an adolescent's world. These transitions set the stage for less

hierarchical relationships between parents and teens (Erwin, 2015:118). This is how the youth culture is developed. When dealing with youth therefore, we need to be conversant with these developmental changes. Importantly, to be a successful youth ministry worker, one must have the passion for the ministry. Dean (2009) argues that passion for youth ministry is key for practical theology in youth ministry. All youth workers must have passion for youth, and ready to develop longlasting relationships with them. If you lack passion, you cannot do anything to the benefits of the youth. In the same way, if we want to address the SRH issues among the youth, we need to study social influence such as peer pressure, music, and both electronic and print media.

The challenge of youth ministry is that it involves the suffering of young people. Therefore, youth ministry needs to view a youth from psychological, and principles of development. To discover theology through Biblical reflections on adolescent development (Borgan 1997:8), we need to look at young people with passionate understanding of adolescent development as a divine creation and providence. Furthermore, we need to consider this as an interdisciplinary task involving theology, and social sciences.

This is where theology of mentorship becomes important to young people. Youth workers must have skills of mentorship to walk with them through their adolescent life challenges. There are different methods one may consider; however, storytelling is one of the theological tools for youth ministry. Thesnaar (2009:124) confirms that story telling provides a better healing process to wounded young people. Workshops are also vital in youth ministry since they will be able to create safe space for youth to open up on some of the issues that affect their sexuality. Thesnaar (2009:127) further notes that during these workshops, various topics may be tackled, and gives opportunity for individuals to reflect, create exercise, and opportunities to share in a small group.

Another approach youth ministry may practically adopt to reach out to the youth is to provide services to the youth. Youth ministry workers should organize retreats, rallies, weekend courses. These methods, and content of these different approaches may respond to the psychological needs of youth, and the approaches are essential to begin youth awakening, and to deeper their understanding of the gospel message (Boran, 1996:23).

Practical theological researchers in youth ministry should also continuously engage in an empirical study that will equip them understanding of emerging issues from the perspective of youth. This will give a proper theological interpretation of some ethical issues that require balancing between lesser and greater evil.

8.4.3.1 Practical Theology Youth Ministry

This study is capable of contributing to guidance on how the church can implement SRH youth ministry programmes theologically. Theology must engage in conversations with those in other disciplines of social, and hard sciences (Root, 2011: 51). The church may wish to bear in mind that youth are human beings who are both spiritual, physical, and sexual beings. When implementing youth ministry activities, the church must consider youth's sexual dignity, and rights, and how best they must protect youth dignity that is free from violation while maintaining their spiritual values.

Furthermore, this research also has potential to empower youth ministry to fight against gender-based violence in the context that young women are treated as sex objects as observed in literature, and during empirical research. Most of the discussions from the respondents had indicated that young women are the most victims of lack of SRH services. By understanding some of the findings of this study, the youth ministry may be guided by the theological values of Imago dei that promotes equality of all human beings created in the image of God.

8.4.4 Limitations and Delimits of the Research

The study was limited to the jurisdiction of CCAP Synod of Livingstonia mainly in the Northern part of Malawi. The participants were all members of CCAP church, and no participant from outside this church was involved in this research. This was to address the specific objectives of the research study. The study covered limited Presbyteries as compared to its size because of limited funds and time; however, the research managed to sample a rural and an urban Presbyteries to obtain balanced information. The study was also limited to practical theological framework to answer the research questions, and the research objectives

8.4.4.1 Recommendations for Further Research

I recommend that synod may conduct further research to fill the gap or answer some questions that might have been triggered or provoked by this study. This is the first study of this kind in the CCAP Synod of Livingstonia. This might have engaged a small community due to a lack of resources, so the synod may wish to conduct another study at a larger scale. Alternatively, the synod may wish to partner with other ecumenical organisations.

I recommend that the next study aims to engage people from other denominations to hear their opinions on what the role of the church in SRH could be. Also, further to that the synod may wish to engage traditional leaders and other elders who are custodians of culture to speak for themselves about the role of culture on SRH among the young ones. This must focus much on gender roles while exposing practices that mostly oppress women.

I would also like to further recommend that in the next proposed research, the synod should engage medical personnel to hear, and explain body development and its demands at different stages of human growth to prove medically whether abstinence will be real, or otherwise since the church emphasises abstinence. I further recommend that the church should find out how much sexual reproductive health could contribute towards poverty reduction in Malawi according to Agenda 2063.

Finally, further recommendation should specifically focus on researching on any existing sexual initiation rites among the northern tribes such as Tumbuka, Tonga, Ngoni, Ngonde, and lambya etc. During this research, it was very difficult to access relevant literature on initiation rites of northern tribes, the catchment area for the study. Most of the sexual cultural practices highlighted in this study were from the central, and Southern part of Malawi.

8.5 Conclusion

Engagements of the church on SRH programmes by breaking the silence through the youth ministry will be helpful in the socioeconomic development of Malawi. This will help to mitigate maternal death among the youth. It will help the youth to complete their education and contribute positively to the economic development of this country as they will be able to acquire economic skills. There will be few, or no early marriages as most of them will have access to SRH services without hindrances. Should the church consider these recommendations by this study, and implement them; it will it be able to fulfil its holistic mission as indicated in the mission statement of Synod of Livingstonia.

Throughout this research from literature review and empirical study, I as a researcher have learned a lot, and discovered that many people follow policies ignorantly, but they can still change and adapt to new ways of doing things should they be given relevant information. It has been a learning process as well. It is my sincere belief that the findings of this research will add some significant information to the body of knowledge within academic circles as well as

influence policy change in some denominations in the country. While it may not be easy to adapt to these recommendations, I trust that with the help of God, it is possible.

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LIST OF APPENDICES

SAMPLE QUESTIONS FOR INTERVIEWS

INDIVIDUAL INTERVIEWS: **MINISTERS AND ELDERS IN THE CCAP SYNOD OF LIVINGSTONIA.**

Transcriber: JG.

Interviewer: JG.

Presbytery: MZ.

Date of Interview: 10th September, 2022

Interview denoted: JG.

Respondent: CE.

1. Age: 59
2. Marital status: Married
3. Position in Church: Church Elder/ Vestry Secretary
4. Name of the Presbytery: Mzuzu

Q1. JG: The following are some of the components of sexual reproductive health. Of which are you familiar from the list below?

(a) Family planning
(b) Prevention of pregnancy and STIs
(c) Prevention of unsafe abortion
(d) Discourage sexual harmful practices
(e) Safe sex
(f) None of the above
(g) All of them

CE 1: I have heard about all these components. But family planning has caused a lot of problems in families, some women who would like to use family planning methods have ended up in family misunderstanding with their husbands. In our culture, a woman can't just start family planning without the consent of the husband.

Q2. **JG**: **Where do you get information on sexual reproductive health?**

(a) Church meetings
(b) Mass media
(c) Posters
(d) Hospital
(e) Friends
(f) Others (specify)

CE1: This information is found mostly at the government hospitals from radios and TVs.

But not at church meetings. It is considered very sensitive in the church, because of our beliefs and I think our culture too has contributed to this silence. I know that posters are all over at

hospitals, clinics, and on radios mainly, on television but we do not talk about these issues at church If there is anything about SRH at church it's through preaching.

Q3. JG: **Where do you think the youth most often get their information about sexual and Reproductive health?**

CE 1: mmmmm…Just suggesting that may be from friends and school I have seen it in the life skills textbooks of my std six Son. They are learning about sex and condoms. We know that they hear from different sources, radios, at school from their friends. Children of this generation are different from us; they know things at a tender age unlike the days in our youth when there was no internet and Facebook. So, they hear from different sources besides from church.

Q4. JG: Which of the following, if any, do you think are negative outcomes of a lack of information on sexual and reproductive health among the youth?

(a) Unwanted pregnancy
(b) Early marriages
(c) Forced marriages
(d) School dropouts
(e) Unsafe abortion

CE 1: All that you have mentioned contributes negatively towards, the health and general welfare of the youth. If she gets pregnant, she cannot continue with her education, at times such children are forced to marry the one responsible. Early marriages contribute to poverty as most of them marry before they finish school and are not even mature enough to make money. There is nothing good from the list you have given us, it is problem after problem, Forced marriage is very common, especially among Christian families, we are forced our you ladies to get married once they get pregnant because we are ashamed to keep a pregnant child at home, we may look like we have failed to teach our children good morals and Christian life very sad indeed. The worst of all is abortion, though you may not have clear evidence only rumors that this one has died because of a failed abortion tell people different reasons for fear of being arrested since in Malawi abortion is illegal, and for Christians is a sin and shameful so people hide. Abortion takes place but people do not talk about it.

Q5. JG: Are these negative outcomes of sexual reproductive health common in your community?

CE1: There are many cases of school dropouts with reasons ranging from, unwanted pregnancies, and forced marriages, and we want to believe that these pregnancies come with STIs as well, many young people are dying from unknown sicknesses, and lots of speculations

about the cause of their deaths. Like I said earlier abortion is the worst only that people do not talk about abortion, but many young people are dying of this unsafe abortion.

Q6. JG: What do you think are contributing factors to the presence of these negative outcomes in your community?

CE 1: There are so many causes one may think of, just our thinking, lack of proper knowledge on how to manage sex life experience, we do not give our young one proper sex education if anything they get wrong information from these numerous sources and friends and media.

Q7. JG: What do you think could be done to limit this negative outcome mentioned above?

CE 1: We need to be open with our young people even at home let alone at church level. If we continue to keep quiet will lose our young people through death. We need to organize seminars for our youth to give them a chance to talk and ask questions about their sexual life as they grow, I think this must be done with trained health personnel and mature church elders, if we remain quiet, they will still ask from their friends about sex life and may end up getting the wrong information.

Q8. JG: Do parents talk to their children about sexual and reproductive health?

CE1: Parents generally do not talk about sex with their biological children, maybe from different families but commonly, no we do not talk because it is a taboo, maybe if anything, you may allow their aunt, uncle, or grandmother to talk to them, however, people still are not comfortable because we do not know what level they talk to them.

Q9. JG: If yes, what is it about sexual and reproductive health that they talk to them about? N/A

Q10. JG: If they do not talk to their children about sexual and reproductive health, why do you think this is so?

CE1: There are several reasons, some are shy, and they fear being misquoted by their children, but generally culture does not allow that conversation between parents and children, which we have just inherited from our forefathers.

Q11. JG: If parents do not or cannot talk to their children on sexual matters, who do you think do talk to them?

CE1: We believe that old women and men in the village and aunts are better placed to talk with children about sex life rather than parents. They act as counsellors to these children.

Q12. JG: How do you feel about forcing a young unmarried couple who fall pregnant to get married?

CE 1: That is not good. It is more like forcing them to marry before they are ready. In most cases, these are very young and immature young people who are forced into marriage. That is child abuse, a right violation…But since it is part of culture there is nothing we can do. The other problem is that this couple may not have enough skills to fight poverty as a result we will create room for continued poverty in our society and villages.

Q13. JG: If, the latter, in your experience, often happens, do you think this should be changed and, if so, how?

CE1: I think this is bad it requires change, sometimes These children impregnate each other out of immaturity and are not ready to manage a family. To be in marriage involves many things that require maturity, we need to change this practice at all costs. We need to allow our young to exercise their rights, especially the right to choose their life partner. All this can change if the church can take the role of counseling young people or start talking about SRH in our churches and homes.

Q14. JG: What do you think parents can do to protect the youth from the negative consequences of a lack of knowledge about sexual and reproductive health?

CE 1: We need to change our mindset as the world is changing, Parents should start opening up with their children about sex life, if they continue to be silent the world through other channels will still give information to youth in most cases wrong information at the wrong ages group parents should change.

Q15. JG: Does your church, CCAP Synod of Livingstonia have guidelines that ministers or elders could use as a guide when talking to youth on aspects of sexual and reproductive health?

(a) If, yes, explain.
(b) If, no, why

CE 1: The answer is no; the synod does not have any guidelines that they can use to teach and guide young people in issues of SRH. This may be the reason we do not talk about SRH in church because we do not have any right way of doing it. If there is any talk about sex life it is only during preaching condemning premarital sex, but we do not guide how to avoid this temptation of premarital sex.

Q16. JG: What does the church do when it becomes aware that an unmarried member of the youth falls pregnant?

CE1: It is very clear in our church practice that one who falls pregnant outside marriage is suspended from church and should not be allowed to partake in any sacraments and not even preach or sing in a choir.

Q17. JG: In your assessment, is the Synod doing enough to guide the youth in the prevention of unwanted pregnancies, and early marriages? Explain.

CE1: In my observation, no, no. The church is not doing much because we only preach condemning the sin of sex outside marriage, but we do not teach them about other issues that affect the sex life of young people. That is the reason I want to thank you for bringing this issue for discussion so that the church can start working on issues of sex among the youth. It is a big problem not only for the church but even for the Nation.

Q18.JG: In 2016, the Synod's Health Department produced a sexual and reproductive health policy for the youth, are you aware of it and have you ever seen it?

(a) If yes, how helpful is this policy document?

(b) If not, why do you think this is so?

CE1: I have not seen nor heard about the sexual Reproductive health policy; it is news to me that Synod has an SRHR policy.

Q19. JG: The Synod sexual reproductive health and rights policy advocates for the rights of youth to access contraceptive services. What is your opinion of this?

CE 1: It is difficult to comment on something that I have not seen, but based on what you have said that it advocates for contraceptives, maybe with proper explanation and how to do it, it sounds good since we have lost many young people because of STI's and rumoured unsafe abortions, maybe it can help but it requires high level of sensitivity and orientation to use that policy.

Q20. JG: To your knowledge, is the church doing anything to assist youth to access contraceptive services and is it adequate? Explain.

CE1: The church is not doing anything that may be known by church members and the church cannot do that if anything like that is happening could be in our mission hospitals, but I doubt it. Maybe individuals are doing it but not at the church level.

Q21. JG: Do you think denying youth access to contraceptives is denying their right to sexual and reproductive health? Explain.

CE1: If you are interested in my opinion, I would say, yes, it is a violation of one's rights. Let one choose what he/she wants, we have preached about abstinence, but we still have pregnancy issues, Salvation is by grace. Those who have not met grace let them practice physical protection. However, it is quite challenging to do so openly as a church because of different levels of faith.

Q22. JG: Do you also think denying youth access to sexual and reproductive health information and services is a violation of the following aspects of human dignity?

(a) Equality
(b) Respect
(c) Love
(d) Inviolability
(e) Rationality

CE1: Yes, I think it is a violation because if we do not allow them to access SRH services, they may end up getting unwanted pregnancies. Furthermore, avoiding shame some may look for ways to abort the pregnancy which may end up to death if is not well done. The only way the church can show love to our young people is by protecting them not falling into SRH problems. The church must show love by protecting young people by preventing them to fall into problems. Also, we need to respect their rights of choice on when to get married. I think every human being deserves equal respect regardless of age.

Q23 JG: Would you like sexual and reproductive health awareness to be included in the youth ministry?

(a) If yes, would you suggest how awareness may be raised as part of the youth ministry program?
(b) If no, please explain**.**

CE1: In my opinion, I would say it is important to consider organizing awareness of SRH among the Youth so that we avoid some of the early marriages, unwanted pregnancies, and the spread of STIs. This can be done well if the church can develop a book to guide counsellors, train some counsellors, and organize workshops by creating a safe space where youth can be free to ask questions about their sex life. However, the church must find better ways of talking about SRH to avoid some misconceptions about the church's beliefs.

Also, the church may consider asking for assistance from our hospitals who can teach our young people in a Christian way. We can also engage (LISAP) Livingstonia Aids Programme our department that deals with HIV/AIDS issues but with consideration of bible teachings. Our church believes in holistic ministry so to include SRH awareness in the Youth ministry will be something very commendable. We should also consider the physical needs rather than Spiritual life alone.

Q24. JG: Any other additional information on how Synod may consider sexual reproductive health as an opportunity and not merely a challenge for youth ministry?

CE1: I want just to thank you for inviting us to talk to you about sex in church, it is the first time to hear a minister talking about sex I wish this could continue until we help our youth to grow into responsible leaders of tomorrow. For a long time, we have not talked openly on sex issues, it is our hope that now we may start talking about it as you have started asking us our thinking. It is my hope that this will continue to be done to others.

Appendix 2: Questionnaire

YOUTH AGED 18-35 IN THE CCAP SYNOD OF LIVINGSTONIA FOCUS GROUP

Name of the Presbytery……

Location of Presbytery……

Age group range……

Number of Participants

Transcriber: J.G. (John Gondwe)

Interviewer: WD. (Willan and Debora)

Presbytery: MZ (Mzuzu)

Date of Interview: 10th January 2023.

Respondent : FGD. Y. (Youth)

Q1. WD. The following are some of the components of sexual reproductive health. Choose any of these you know.

(a) Family planning
(b) Prevention of pregnancy
(c) Prevention of unsafe abortion
(d) Discourage sexual harmful practices
(e) Safe sex
(f) None of the above
(g) All of them

FGD.Y. 1: All that you have mentioned are familiar to us we hear them on the radio. Only harmful sexual practices that we hear at school. However, even if we hear about the prevention of pregnancy and family planning, it is not acceptable in our society for young people to seek contraceptives anywhere. It is a taboo; young people do not even think about contraceptives at all. Even married people in our villages do not allow them because they say contraceptives kill the womb that helps women bear children.

FGD.Y. 1: You asked about the prevention of unsafe abortion, we do not even have safe abortion chances, it is against our faith, abortion is murder and it's a crime, you can be arrested. But we hear about deaths rumored to have been caused by attempted abortion, but people do not come out clear because it is a sensitive issue in our villages.

FGD.Y. 2: I have never heard of any of these in my life, how can one prevent pregnancy, yet you are not married?

WD: Do you mean even at school you have not heard about safe sex? Who else has not listened to any of these?

FGD.Y. 1: Mmmmm.... Many of us have heard about them Some of us are shy we fear being accused of being immoral. Many are afraid to be judged because in our society sexual issues are very sensitive to be discussed openly like this Sir.

Q2. WD: Where did most of your peers get information on the aspects of sexual reproductive health mentioned above?

(a) Parents
(b) Teachers
(c) Mass media
(d) Church
(e) Hospital
(f) Peers (fellow youth)
(g) Others (specify)

FGD.Y. 2: Most young people get information about SRH from media sources, friends, and school subjects mainly on life skills. From parents, we only hear commands and mainly they talk in parables when they hear about stories of young men and young ladies being involved in premarital sex. Otherwise, parents do not have that time.

WD: You talked about parents giving commands are those commands helpful or not?

FGD.Y. 2 The commands at times come as a threat not advising of teaching, they only condemn without giving alternatives, and they abstain but at times abstinence does not work What should one do? So, they should have given us such opportunities.

Q 3. WD. Where did you get information about matters of sexual and reproductive health from?

FGD Y 4. We get this information from radios and television at school, and on social media; but mostly, we discuss these issues with friends at school.

FGD. Y. 3. Our aunt was sent to teach me about hygiene after the puberty period, and they taught me about the dangers of sleeping with men. You can get pregnant, and men will run away from you so be careful.

Q4 WD: Explain how the information helps you.

FGD.Y. 1: The information helped us to know the dangers of having unprotected sex because you can easily get pregnant and STIs. We were also told about the dangers of getting rid of pregnancy because one can die if it goes wrong, or you may destroy your womb and not have children when you get married.

FGD. Y 2: My aunt used to tell us about the dangers of being involved in premarital sex. She said it is dangerous, one may get infections such as HIV Aids, and pregnancy and one will stop schooling. So since then, I have feared men so much.

Q5 WD: Do the sources mentioned above give the same information or does the information they are providing? Discuss.

FGD Y 2: In most cases, information is the same. Only what may be on television is always brief, but when we discuss with friends it gives more information because we engage each other with questions.

Q6 WD: Who can you freely talk to about sexual reproductive health?

(a) Teachers
(b) Parents
(c) Church leaders
(d) Friends
(e) Other (specify)

FGD Y 1 We are very free to discuss SRH issues with friends because we speak the same language.

Q7 WD: Are you more comfortable talking about sexual and reproductive health with some of the above examples than with others and why so?

FGD Y 1: Very uncomfortable talking with teachers, we only talk and learn to pass examinations. We fear asking many questions in class because fellow students may laugh at us, or we may look like we are immoral. we do not talk with parents, but they only tell us not to be involved in premarital sex without proper reasons. Our parents do not open, and even if they open, I do not think we can talk much. In our culture mmmm, it is difficult.

Q8 WD: According to literature parents prefer not to talk about sexual matters to their children. Is that true in your experience?

FGD Y 2 It is very true; it is very unusual.

WD: If so, why do you think this is so?

FGD Y 2: Our culture does not permit children and parents to discuss sexual life issues, I do not why but we grew up knowing that we do not talk, maybe it is a taboo…, we do not know, maybe some families talk…

Q 9: WD: What do you think could be done by the church to assist both parents and youth to be more comfortable speaking about sexual matters constructively?

FGD Y 1: We think the best way is to consider the problems that come because of a lack of knowledge on how to handle sexual issues. if our leaders consider this, they may be able to talk to us. Most of my friends are married while young some are dying from unknown diseases.

WD: Which of the following are adverse outcomes of a lack of openness about sexual and reproductive health?

(a) Unwanted pregnancy
(b) Early marriages
(c) Forced marriages
(d) School dropout
(e) Unsafe abortion

FGD Y 2 All that you have mentioned is a problem for us young people because some of us are ignorant about how to prevent those problems that come with improper use of sexual life.

WD: Are any of the above-mentioned negative outcomes common in your community?

FGD Y 1: Those are very common, forced marriages and unwanted pregnancies are very common, if we talk about school dropouts it is rated several all the problems. Unsafe abortion though not very clear but we hear about rumors of some young people dying from complications of unsafe abortions. Abortion is something prohibited in our community.

WD: What do you think are contributing factors why this is so?

FGD Y 1: We think maybe parents do not take a major role in advising us on issues of sexual life, if our parents were able to teach us, I think most of us youth would be able to avoid these sexual health problems. We always listen to parents for advice.

Q10: WD What do you do to prevent these negative sexual reproductive outcomes?

FGD Y1: We avoid premarital sex, we do not play with girls and boys, we depend on prayer as we are taught at church…. That is all.

WD: In your own opinion, is the Synod doing enough to make the youth aware of and to assist regarding the above negative outcomes?

FGDY 1: There is nothing we can point out that the synod is doing on SRH, surely, we do not hear anything at church apart from preaching that condemns the sin of fornication that is all.

Q11: WD Would you like sexual reproductive health awareness for youth to be included in the youth ministry programme?

(a) If yes, would you suggest what must be done……
(b) If no, why?

FGD Y 2: Looking at the situation in which we are now if the church can find a way to guide us on SRH issues will be very helpful, we may be able to avoid mysterious deaths associated with rumuors of failed abortions and the spread of STIs. The best way could be to organize seminars and give us space to discuss and ask questions about SRH.

WD: What could young people do to enhance sexually productive health in their own lives and that of their peers?

FGD Y 1: The best way is to be exposed to SRH services; this may help most of us young people to know how to prevent unwanted pregnancies.

Q12 WD Have you seen and read the sexual reproductive health policy developed by the Synod Health Department?

FGD Y 1: We have never seen nor heard about the SRHR policy of the synod. We are hearing it for the first time from you. How we wish we could have seen this document otherwise we could have learned something from it.

WD: Do you have any other additional information? Discuss.

We are just appealing to our church to find a better way of helping us as young people on how best we must access SRH services. This will help us not to lose fellow Youth through STIs and unwanted pregnancy that is forcing some into early marriages.

Appendix 3: Research Ethics Approval

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

RESEARCH ETHICS APPROVED WITH CONDITIONS
REC: Social, Behavioural and Education Research (SBER) - Initial Application Form

9 September 2022

Project number: REC: SBE-2022-24890

Project title: BREAKING THE SILENCE: SEXUAL AND REPRODUCTIVE HEALTH A CHALLENGE OR OPPORTUNITY FOR YOUTH MINSTRY, CCAP SYNOD OF LIVINGSTONIA

Dear Mr J Gondwe

Your REC: Social, Behavioural and Education Research (SBER) - Initial Application Form submitted on 11/07/2022 09:48 was reviewed by the Social, Behavioural and Education Research Ethics Committee (REC: SBE) and has been approved with certain conditions.

This conditional approval means that you may proceed with your planned research, provided that you adhere or respond to the stipulations/conditions provided below.

Your research ethics approval is valid for the following period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
9 September 2022	8 September 2023

REC STIPULATIONS/CONDITIONS:

1) The following sentence in the informed consent form (ICF) should be reworded, "Make sure that you have understood the objective of this exercise and your participation is very important no need to withdrawal until you finish the exercise." Participants should be allowed to withdraw from the study at any point, without consequence. Please add to the ICF what will happen to the data of those who withdraw. [EDIT REQUIRED]

2) Participants should be provided with a snack and water on the day of the interview. Some token of appreciation for their time and effort is required. [RESPONSE REQUIRED]

How to respond to the REC: SBE's comments/questions:

Click on the links provided below for steps on how to edit your online application to respond to this request for modifications:

Instructional video (See: How to edit your online application)

FAQ guide (See: Form FAQs > How to revise/edit my online form)

Template for response letter (See Other templates > Response letter template)

INVESTIGATOR RESPONSIBILITIES

1. Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

2. Your approval is based on the information you provided in your online research ethics application form. If you are required to make amendments to or deviate from the proposal approved by the REC, please contact the REC: SBE office for advice: applyethics@sun.ac.za

3. Always use this project ID number (24890) in all communications with the REC: SBE concerning your project.

4. Please note that the REC has the prerogative and authority to ask further questions, seek additional information, and monitor the conduct of your research and the consent process, where required.

RENEWAL OF RESEARCH BEYOND THE REC EXPIRATION DATE

You are required to submit a progress report to the REC: SBE before the project approval period expires if renewal of ethics approval is required.

If you have completed your research, you are required to submit a final report to the REC: SBE to close the active REC record for this project.

Project documents approved by the REC:

Document Type	File Name	Date	Version
Default	CV CLOETE ANITA LOUISA 2021	26/03/2022	CV
Request for permission	SYNOD CLEARANCE	27/03/2022	CLEARANCE
Default	SYNOD ETHICAL CLEARANCE (1)	22/04/2022	Synod Ethical Cleara
Budget	BUDGET FOR THE RESEACH PROJECT	06/07/2022	MODIFIED
Informed Consent Form	SU HUMANITIES ICF YOUTH resubmitted	06/07/2022	MODIFIED
Informed Consent Form	SU HUMANITIES ICF ELDERS AND PASTORS resubmitted	06/07/2022	MODIFIED
Data collection tool	GONDWE FINAL Interview schedule_elders and pastors	06/07/2022	MODIFIED
Data collection tool	GONDWE FINAL QUESTIONNIARE_Youths for submission	06/07/2022	MODIFIED
Recruitment material	Recruitment Flyer	06/07/2022	FLYER
Letter of support_counselling	Rev. J. Gondwe	07/07/2022	Modified
Non-disclosure agreement	25062020 NDA INTERNAL-FIELDWORKER_(amended)	07/07/2022	Amended
Default	Ethics Response Letter_Gondwe_for submission	07/07/2022	RESPONSE LETTER
Research Protocol/Proposal	RESEARCH PROPOSAL for REC_no tracks	07/07/2022	MODIFIED

If you have any questions or need further help, please contact the REC office at applyethics@sun.ac.za.

Sincerely,

Mrs Clarissa Robertson (cgraham@sun.ac.za)
Secretariat: Social, Behavioural and Education Research Ethics Committee (REC: SBE)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Social, Behavioural and Education Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Principal Investigator Responsibilities

Protection of Human Research Participants

As soon as Research Ethics Committee approval is confirmed by the REC, the principal investigator (PI) is responsible for the following:

Conducting the Research: The PI is responsible for making sure that the research is conducted according to the REC-approved research plan. The PI is jointly responsible for the conduct of co-investigators and any research staff involved with this research. The PI must ensure that the research is conducted according to the recognised standards of their research field/discipline and according to the principles and standards of ethical research and responsible research conduct.

Participant Enrolment: The PI may not recruit or enrol participants unless the strategy for recruitment is approved by the REC. Recruitment and data collection activities must cease after the expiration date of REC approval. All recruitment materials must be approved by the REC prior to their use.

Informed Consent: The PI is responsible for obtaining and documenting affirmative informed consent using **only** the REC-approved consent documents/process, and for ensuring that no participants are involved in research prior to obtaining their affirmative informed consent. The PI must give all participants copies of the signed informed consent documents, where required. The PI must keep the originals in a secured, REC-approved location for at least five (5) years after the research is complete.

Continuing Review: The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is the PI's responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur.** Once REC approval of your research lapses, all research activities must cease, and contact must be made with the REC immediately.

Amendments and Changes: Any planned changes to any aspect of the research (such as research design, procedures, participant population, informed consent document, instruments, surveys or recruiting material, etc.), must be submitted to the REC for review and approval before implementation. Amendments may not be initiated without first obtaining written REC approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

Adverse or Unanticipated Events: Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the REC within **five (5) days** of discovery of the incident. The PI must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants.

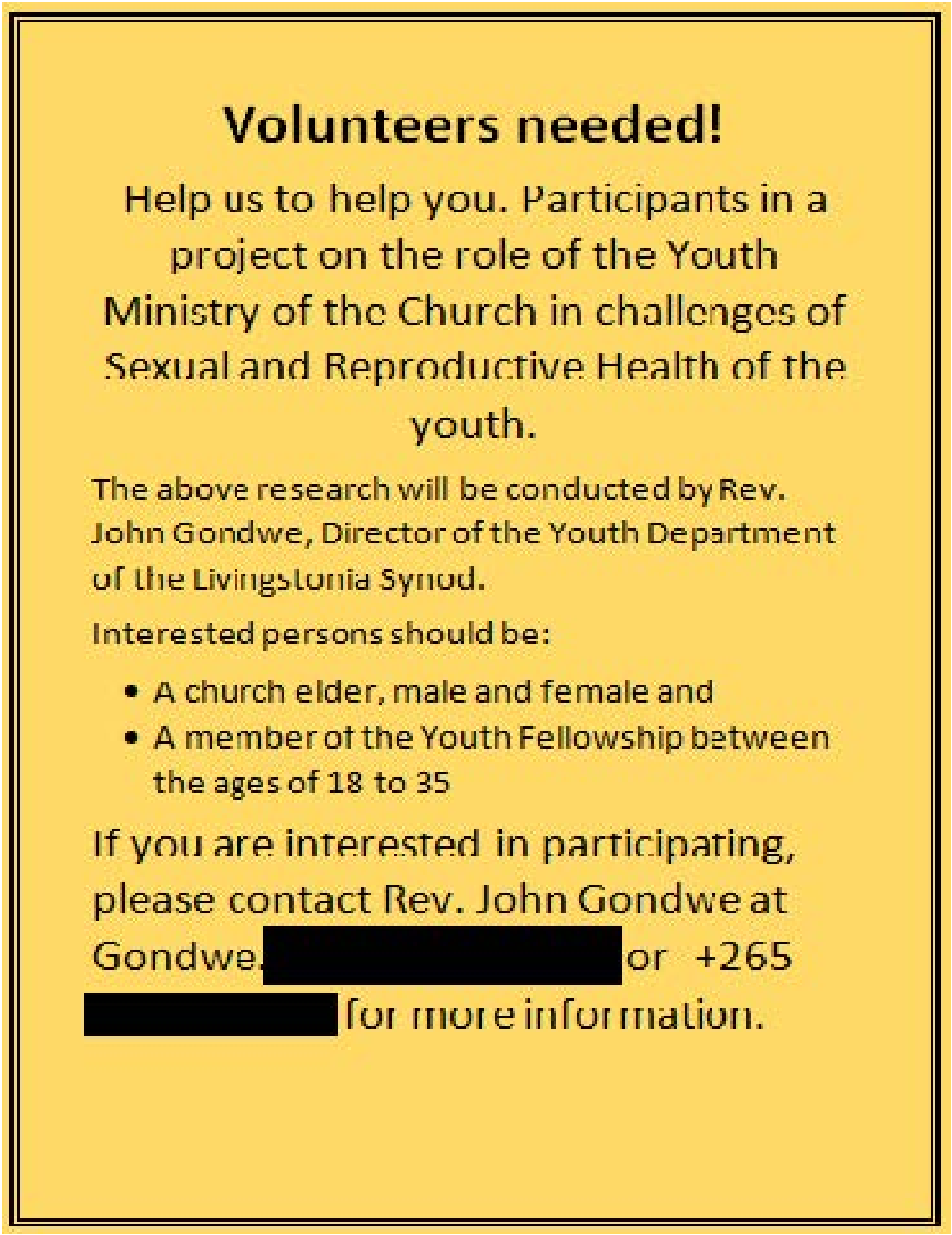
Research Record Keeping: The PI must keep the following research-related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence and approvals from the REC.

Provision of Counselling or emergency support: When a dedicated counsellor or a psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

Final reports: When the research is completed (no further participant enrolment, interactions or interventions), the PI must submit a Final Report to the REC to close the study.

On-Site Evaluations, Inspections, or Audits: If the researcher is notified that the research will be reviewed or audited by the sponsor or any other external agency or any internal group, the PI must inform the REC immediately of the impending audit/evaluation.

Appendix 4: Recruitment Flyer



Appendix 5: Assurance of Psychological Care for Research Participants

Saint John of God Hospitaller Services

Registered company under Companies Act 1984

07 July 2022

Rev. John Gondwe
University of Livingstonia, Kaning'ina Campus
Mzuzu
MALAWI

Dear Sir,

ASSURANCE OF PSYCHOLOGICAL CARE FOR RESEARCH PARTICIPANTS DURING YOUR RESEARCH PROCESS.

I write to assure you that St. John of God Hospitaller services will make its services available to support any of your research participants or staff that may be distressed during your research process.

As providers of holistic mental health services in Malawi, and looking at the importance of this research, we pledge to support it through the whole period when it will be conducted.

Please feel free to refer to us any person who, due to participation or otherwise, may be affected psychologically. Our well-trained mental health professionals will be happy to assist accordingly.

For further details, please contact us on the contacts below.

Yours faithfully,

Dr. Charles Masulani
CHIEF EXECUTIVE OFFICER

P.O. Box 744
Katoto, Mzuzu,
Malawi

Tel: 265 (0) 1 311 495 Fax: 265 (0) 1 311 213 Email: sjog@sjog.mw Web: www.sjog.mw

Hospitality . Compassion . Respect . Justice . Excellence

All Correspondence should be addressed to the CHIEF EXECUTIVE OFFICER

Appendix 6: Synod Ethical Clearance

CHURCH OF CENTRAL AFRICA PRESBYTERIAN

SYNOD OF LIVINGSTONIA

Tel : 01 311 344
Fax: 01 311 111
Email: secretariat@ccapsolinia.org

Synod Office
Boardman Road
P.O Box 112
Mzuzu
MALAWI

Ref.:

22nd April, 2022

TO WHOM IT MAY CONCERN

ETHICAL CLEARANCE TO CONDUCT EMPIRICAL RESEARCH IN THE CCAP SYNOD OF LIVINGSTONIA

I write to authorize Rev. John Gondwe PhD student at Stellenbosch university student number 16607961 to conduct his empirical research within the jurisdiction of CCAP Synod of Livingstonia. John Gondwe is working on the Project reference number 24890, under the topic entitled " BREAKING THE SILENCE ON SEXUAL REPRODUCTIVE HEALTH AMONG THE YOUTH IN THE CCAP SYNOD OF LIVINGSTONIA: A THEOLOGICAL CHALLENGE AND OPPORTUNITY FOR YOUTH MINISTRY."

This project investigation's findings shall benefit not only CCAP Synod of Livingstonia but the entire church in Malawi as it will give a proper theological guidance to address issues of sexual reproductive health among the youth in the Church.

Furthermore, the findings of this research shall be published as a hand book for counselling and guidance for youth as well as an academic document. It shall also give an opportunity for wider research on the same topic as it is the first research topic in the CCAP Synod of Livingstonia.

Signed:

Rev William B. Tembo
GENERAL SECRETARY

CHURCH OF CENTRAL AFRICA PRESBYTERIAN
22 APR 2022
SYNOD OF LIVINGSTONIA
P.O.BOX 112, MZUZU

Appendix 7: Consent of Participant in Research

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a research project. Please take some time to read the information below which will explain the details of this research project.

Please feel free to contact the researchers about any part of this project that you do not fully understand. It is very important that you are completely satisfied that you clearly understand what this research is about and how you could be involved.

Your participation is completely voluntary, and you are free to decline to participate. In other words, you may choose to take part, or not. Saying no will not affect you negatively in any way whatsoever.

Make sure that you have understood the objective of this exercise and your participation is very important. You may withdraw from this exercise anytime you feel you can't continue with this exercise. However, you may allow me to continue using the information given during this part of the interviews. Furthermore, the data collected from these people will be kept safely like any other data collected during this exercise.

The Research Ethics Committee: Social, Behavioural, and Education Research at Stellenbosch University has approved this study (Project ID #: 24890). We commit to conducting the study according to the ethical guidelines and principles of the South African Department of Health Ethics in Health Research: Principles, Processes, and Studies (2015).

1. WHO IS CONDUCTING THIS STUDY?

I am Rev. John Gondwe from the CCAP Livingstonia Synod and a Ph.D. student in the Department of Practical Theology and Missiology at the Faculty of Theology of the University of Stellenbosch, South Africa. The topic of my research is "BREAKING THE SILENCE: SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE OR OPPORTUNITY FOR YOUTH MINISTRY."

2. WHY DO WE INVITE YOU TO PARTICIPATE?

We are inviting you to participate because you are an elder or pastor in the CCAP Synod of Livingstonia with an interest in the youth and youth ministry in the Church.

3. WHAT IS THIS RESEARCH PROJECT ABOUT?

The research wants to find out what you as an elder or pastor think of sexual and reproductive health, what it is, why it is important, specifically for the youth members of the church, and whether you know where they can find information and services on it. It also wants to know whether, as an elder or pastor, you think the Church is or should be (or not) involved in issues of young people's sexual and reproductive health, especially via its youth ministry. In short, whether the Church is silent on issues of youth sexual and reproductive health and whether it should be.

4. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to participate in an individual interview with me on the above topic. The interview will take place at a time and place convenient to you will not last more than 60 minutes and may be recorded.

5. ARE THERE ANY RISKS IN MY TAKING PART IN THIS RESEARCH?

There are no foreseeable risks in your participation in the study. You may leave the discussion at any time, and you will not be expected to answer any question that makes you feel uncomfortable. If so, this will have no negative consequences for you whatsoever.

6. WILL I BENEFIT FROM TAKING PART IN THIS RESEARCH?

There will be no direct benefit for you in participating in the study; however, you will help the Church to better understand different perspectives on the challenges faced by young people regarding sexual and reproductive health issues. This may lead to better church policies, programs, or youth ministry that may assist young people in taking better care of their sexual and reproductive health.

7. WILL I BE PAID TO TAKE PART IN THIS STUDY AND ARE THERE ANY COSTS INVOLVED?

You will unfortunately not be paid for your participation. However, you will be provided with some snacks and refreshments during the interview exercise.

8. WHO WILL HAVE ACCESS TO MY INFORMATION?

Any information you share with me during this study that could identify you as a participant will be protected. Notes and recordings that may have been taken during the interview will be stored in a secure location where no one can access it and it will be destroyed after the research has been done. No names of participants shall ever be published.

9. HOW DO I MAKE CONTACT WITH THE RESEARCHERS?

If you have any questions or concerns about this study, please feel free to contact me Rev. John Gondwe at [redacted]@sun.ac.za or my study supervisor Prof. Anita Cloete at acloete@sun.ac.za.

10. RIGHTS OF RESEARCH PARTICIPANTS

If you have questions, concerns, or a complaint regarding your rights as a research participant in this research project, you may also contact Mrs. Clarissa Robertson [cgraham@sun.ac.za; (+27) 021 808 9183] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant, I declare that:

- I have read this information and consent form, or it was read to me, and it is written in a

- I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and with which I am comfortable.
- I have had a chance to ask questions and I am satisfied that all my questions have been answered.
- I understand that taking part in this study is voluntary, and I have not been pressurized to take part.
- I may choose to leave the study at any time and nothing bad will come of it – I will not be penalized or prejudiced in any way.
- I agree that the interview with me can be [video-recorded / audio-recorded].

By signing below, I _____ *(name of participant)* agree to take part in this research study, as conducted by _____ *(name of principal investigator).*

_____ _____

Signature of Participant **Date**

DECLARATION BY THE RESEARCHER

As the **researcher,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition, I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant was fluent.
	I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.)

_____ _____

Signature of Principal Investigator **Date**

_____ _____

Signature of Interpreter (if applicable) **Date**

Appendix 8: Consent of Participant in Research

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a research project. Please take some time to read the information below which will explain the details of this research project.

Please feel free to contact the researchers about any part of this project that you do not fully understand. It is very important that you are completely satisfied that you clearly understand what this research is about and how you could be involved.

Your participation is completely voluntary, and you are free to decline to participate. In other words, you may choose to take part, or not. Saying no will not affect you negatively in any way whatsoever.

Make sure that you have understood the objective of this exercise and your participation is very important. You are free to withdraw anytime you feel you cannot proceed with the interview exercise. However, you may permit me to continue using the information given so far. In addition, the data collected will be kept safely like any data collected from this interview.

The Research Ethics Committee: Social, Behavioural, and Education Research at Stellenbosch University has approved this study (Project ID #: 24890). We commit to conducting the study according to the ethical guidelines and principles of the South African Department of Health Ethics in Health Research: Principles, Processes and Studies (2015).

1. WHO IS CONDUCTING THIS STUDY?

I am Rev. John Gondwe from the CCAP Livingstonia Synod and a Ph.D. student in the Department of Practical Theology and Missiology at the Faculty of Theology of the University of Stellenbosch, South Africa. Joining me in the research are two research assistants, Willan Kalinda and Debora Sichone. The topic of my research is "BREAKING THE SILENCE: SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE OR OPPORTUNITY FOR YOUTH MINISTRY."

2. WHY DO WE INVITE YOU TO PARTICIPATE?

We are inviting you to participate because you are a member of a youth fellowship in CCAP in this area and between the ages of 18 and 35.

3. WHAT IS THIS RESEARCH PROJECT ABOUT?

The research wants to find out what you as a young person think of sexual and reproductive health, what it is, why it is important, and where one can find information and services on it. It also wants to know whether you think the Church is or should be (or not) involved in issues of young people's sexual and reproductive health, especially via its youth ministry. In short, whether the Church is silent on issues of youth sexual and reproductive health and whether it should be.

4. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to participate with five other members of the youth fellowship in your area in a discussion on the above topic. Your opinions as the youth of the Church are important and this will be an opportunity to share these. The discussion will be held at a time convenient to the group at your Presbytery office. The discussion will be led by the research assistants who are also young people and members of the youth fellowship. The discussion will not take more than 60 minutes.

5. ARE THERE ANY RISKS IN MY TAKING PART IN THIS RESEARCH?

You may leave the discussion at any time, and you will not be expected to answer any question that makes you feel uncomfortable. If so, this will have no negative consequences for you whatsoever. If any of the questions or aspects of the discussion upsets you and you wish to talk to someone about it, you are welcome to do so with me. Should you rather speak to someone else you are welcome to contact Dr. Charles Masulani of the Saint John of God Hospitaller Services at + (265) 1 311690 / + (265) 1 31149 or sjog@sjog.mw, for free counseling.

6. WILL I BENEFIT FROM TAKING PART IN THIS RESEARCH?

You may benefit by sharing your views on a subject that may be very important to you, but you will help the Church to better understand the challenges you face as young people regarding sexual and reproductive health issues. This may lead to better church policies, programs, or youth ministry that may assist young people to take better care of their sexual and reproductive health.

7. WILL I BE PAID TO TAKE PART IN THIS STUDY AND ARE THERE ANY COSTS INVOLVED?

You will not be paid for your participation, but refreshments and snacks will be provided during the interview exercise.

8. WHO WILL HAVE ACCESS TO MY INFORMATION?

Any information you share with me during this study that could identify you as a participant will be protected. Not the Church, your minister, or anyone else will know that you have participated or what was said was said by you. However, the research assistants leading the discussion groups and the fellow members of the discussion groups will know what has been said. This makes it VERY important that the confidentiality of what is shared during the discussions is respected by everyone. Notes and recordings that may have been taken will be stored in secure locations where no one can access them, and they will be destroyed after the research has been done. No names of participants shall ever be published.

9. HOW DO I MAKE CONTACT WITH THE RESEARCHERS?

If you have any questions or concerns about this study, please feel free to contact me Rev. John Gondwe at 16607961@sun.ac.za or my study supervisor Prof. Anita Cloete at acloete@sun.ac.za.

10. RIGHTS OF RESEARCH PARTICIPANTS

If you have questions, concerns, or a complaint regarding your rights as a research participant in this research project, you may also contact Mrs. Clarissa Robertson [cgraham@sun.ac.za; (+27) 021 808 9183] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant, I declare that:

- I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and with which I am comfortable.
- I have had a chance to ask questions and I am satisfied that all my questions have been answered.
- I understand that taking part in this study is voluntary, and I have not been pressurized to take part.
- I may choose to leave the study at any time and nothing bad will come of it – I will not be penalized or prejudiced in any way.
- I agree that the interview with me can be [video-recorded / audio-recorded].

By signing below, I _____ *(name of participant)* agree to take part in this research study, as conducted by _____ *(name of principal investigator)*.

_____ _____

Signature of Participant **Date**

DECLARATION BY THE RESEARCHER

As the **researcher,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition, I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant was fluent.
	I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.)

_____ _____

Signature of Principal Investigator **Date**

_____ _____

Signature of Interpreter (if applicable) **Date**

REC: SBE_General ICF template_December 2021

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Appendix 9: Confirmation of research ethical approval

Stellenbosch UNIVERSITY IYUNIVESITHI UNIVERSITEIT
forward together
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saam vorentoe

CONFIRMATION OF RESEARCH ETHICS APPROVAL

REC: Social, Behavioural and Education Research (SBER) - Initial Application Form

4 September 2023

Project number: 24890

Project Title: BREAKING THE SILENCE: SEXUAL AND REPRODUCTIVE HEALTH A CHALLENGE OR OPPORTUNITY FOR YOUTH MINSTRY, CCAP SYNOD OF LIVINGSTONIA

Dear Mr J Gondwe

Identified supervisor(s) and/or co-investigator(s):

Prof AL Cloete

Your REC: Social, Behavioural and Education Research (SBER) - Initial Application Form submitted on 29/08/2023 11:13 was reviewed and approved by the Social, Behavioural and Education Research Ethics Committee (REC: SBE).

This approval is only valid until the end of the protocol approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
9 September 2022	8 September 2023

GENERAL COMMENTS PERTAINING TO THIS PROJECT:

INVESTIGATOR RESPONSIBILITIES

1. Please take note of the General Investigator Responsibilities attached to this letter.
2. Always use your project ID number (24890) in all correspondence with the REC: SBE concerning your project.
3. Please note that the REC has the prerogative to ask further questions, seek additional information, and monitor the conduct of your research and the consent process, where required.

List of documents approved by the REC: SBE:

Document Type	File Name	Date	Version
Default	CV CLOETE ANITA LOUISA 2021	26/03/2022	CV
Request for permission	SYNOD CLEARANCE	27/03/2022	CLEARANCE
Default	SYNOD ETHICAL CLEARANCE (1)	22/04/2022	Synod Ethical Cleara
Budget	BUDGET FOR THE RESEACH PROJECT	06/07/2022	MODIFIED
Informed Consent Form	SU HUMANITIES ICF YOUTH resubmitted	06/07/2022	MODIFIED
Informed Consent Form	SU HUMANITIES ICF ELDERS AND PASTORS resubmitted	06/07/2022	MODIFIED
Data collection tool	GONDWE FINAL Interview schedule_elders and pastors	06/07/2022	MODIFIED
Data collection tool	GONDWE FINAL QUESTIONNIARE_Youths for submission	06/07/2022	MODIFIED
Recruitment material	Recruitment Flyer	06/07/2022	FLYER

Document Type	File Name	Date	Version
Letter of support_counselling	Rev. J. Gondwe	07/07/2022	Modified
Non-disclosure agreement	25062020 NDA INTERNAL-FIELDWORKER_(amended)	07/07/2022	Amended
Default	Ethics Response Letter_Gondwe_for submission	07/07/2022	RESPONSE LETTER
Research Protocol/Proposal	RESEARCH PROPOSAL for REC_no tracks	07/07/2022	MODIFIED

If you have any questions or need further help, please contact the REC administrative officer, Mr Aden Williams at aden@sun.ac.za

Sincerely,

Mrs Clarissa Robertson (cgraham@sun.ac.za)

Secretariat: Social, Behavioral and Education Research Ethics Committee (REC: SBE)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Social, Behavioural and Education Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.