FACTORS INFLUENCING IMPLEMENTATION OF REPRODUCTIVE HEALTH EDUCATION IN PUBLIC SECONDARY SCHOOLS IN URIRI DISTRICT, MIGORI COUNTY

BY

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DECLARATION

This research project is my original work and has never been presented for the award of any degree in any other University.

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DEDICATION

This research project is dedicated to my wife Josphine Were and my children Alvin Were and Lynne Aoko for their support and encouragement during the development of this work.

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LIST OF ABBREVIATIONS AND ACRONYMS

BBC: British Broadcasting Corporation

FHI: Family Health International

G & C: Guidance and Counseling

HIV/AIDS: Human Immune Virus/Acquired Immune Deficiency Syndrome

ICPD: International Conference on Population and Development

IEC: Information, Education and Communication

IPPF: International Planned parenthood federation

KARP: Kenya Adolescent Reproductive Health project

KDHS: Kenya Demographic Health Survey

NGOs: Non-Governmental Organizations

NSAST: National Survey of Australian Secondary Teachers

RHE: Reproductive Health Education

SEICUS: Sexuality Information and Education Council of the United States

SHEP: School Health Education Programme

SLD: Sexuality Leadership Development

STDs: Sexually Transmitted Diseases

STIs: Sexually Transmitted Infections

T &L: Teaching and Learning

U.S.: United States

UNAIDS: United Nations Acquired Immune Deficiency Syndrome

UNDP: United Nations Development Programme

UNESCO: United Nations Education, Scientific and Cultural Organization

UNFPA: United Nations Funds for Population Development

UNICEF: United Nations Children Education Fund

UN: United Nations

USAID- United States of America International Development

WHO: World Health Organization

RHE: Reproductive Health Education

G & C: Guidance and Counseling

T-L: Teaching and Learning

ABSTRACT

The study was to investigate the factors influencing the implementation of reproductive health education in public secondary schools in Uriri District, Migori County. The study was investigated through the following objectives; to establish the extent to which the school curriculum influence the implementation of reproductive health education in public secondary schools, to determine the extent to which school management influence the implementation o reproductive health education, to investigate how teachers influence the implementation of reproductive health education, to establish the extent to which resource materials influence the implementation of reproductive health education and finally to determine how school sponsors influence implementation of reproductive health education in public secondary schools. This study is to help students acquire health education knowledge, enhance wellness behavior, promote healthy situations, facilitate helpful relationship and enable students make responsible decisions. Health instructions help learners to develop resistance skills when appropriate, promote protective factors, ensure resilience in terms of the ability prevent or recover fro sickness. The research will experience limitations of non response from respondents, error or the potential of substituting a sampling unit in the field. The study will be limited to all public secondary schools in Uriri district. The study assumed the school administrator allowed the teachers and the pupils to participate in the study, representative sampled, instruments valid and reliable, and respondents were to give information honestly and directly. Literature has been discussed in terms of school curriculum, school management, teachers, resource materials and school sponsors. The study was conducted through descriptive research survey and correlation research design to examine and describing the associations and relationships between two variables. 17 public secondary schools with 30 school managers and 120 teachers were targeted and a sample size of 108 was picked. The targeted population was stratified according to wards the school managers and teachers were sampled then a complete census was applied to get 150 respondents. The data was collected through self administered questionnaires. The data collected was presented using the chi-square tables basing on the research hypothesis. Quantitative data was analyzed using statistical package for social sciences (SPSS) version 19 both for windows, while qualitative data was presented by way of narration. It was found out that there was significant relationship between the curriculum, teachers, resource materials, school management and to some extent the school sponsors with implementation of reproductive health education. Due to results of the study, it was recommended that reproductive health education to be; taught and examined, mainstreamed in the curriculum, teachers to be trained. Thus, a study to be conducted to establish factors promoting adolescents pregnancy in the country and another study to establish low uptake of reproductive health services among adolescents in Kenya.

CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

Reproductive health education is taught in our secondary schools through family life education whilst in some schools it is offered by Non-Governmental organizations since it is not in the mainstream curriculum, despite this, there are numerous problems associated with reproductive health that face youths in Uriri District and the country at large. There is rampant teenage pregnancy reported in the media, journals and periodicals. Sexually transmitted infections, high school drop outs and high incidences of abortion among others, then, why are these problems bedeviling the youths despite the interventions by school teachers and NGOs. Are the implementers concentrating more on the examinable subjects or Are the school managers not giving enough support for the implementation of reproductive health or are the teachers more engaged with the examinable subjects or are the learning and teaching materials not available or the school sponsors exerts a lot of pressure on part of the school managers and teachers not to implement the reproductive health in the school?

Globally, all U.S students receive some form of sex education at least once between grades 7 and 12; many schools begin addressing some topics in grades 5 or 6 (Family planning perspectives 32(5) September/October 2000). However, what students learn varies widely, because curriculum decisions are so decentralized. Many states have laws governing what is taught in sex education classes or allowing parents to opt out. Some state laws leave curriculum decisions to individual school districts (http://www.kff.org/org/youthhivstds/upload/Sex-Education-in-theU-S-Policy-and-Politics.pdf). For example, a 1999 study by the Guttmacher Institute found that most U.S. sex education courses in grades 7 through 12 cover puberty , HIV, STIs, abstinence, implications of teenage pregnancy, and how to resist peer pressure.

In India, there is a huge debate on the curriculum of sex education and whether it should be introduced at all. Attempts by state governments to introduce sex education as a compulsory part of the curriculum have often been met with harsh criticism by political parties, who claim that sex education “is against Indian culture” and would mislead children (Leepson 2002). The state of sex education programs in Asia is at various stages of development. In Germany sex education

has been part of school curriculum since 1970. Then by 1992 sex education was by law a government duty. It normally covers all subjects concerning the growing-up process, body changes during puberty, emotions, the biological process of reproduction, sexual activity, partnership, homosexuality, unwanted pregnancies and the complications of abortion, the dangers of sexual violence, child abuse, and sex-transmitted diseases, but sometimes also things like sex positions. Most schools offer courses on the correct usage of contraception (Sexualkunde-SchmutzigeGedanken (German)).

Indonesia, Mongolia, South Korea have a systematic policy framework for teaching about sex within schools. Malaysia and Thailand have assessed adolescent reproductive health needs with a view to developing adolescent-specific training, messages and materials. Bangladesh, Myanmar, Nepal and Pakistan have no coordinated sex education. In Japan, sex education is mandatory from age 10 or 11, mainly covering biological topics such as menstruation and ejaculation (United Nations Social and Economic Commission, 2009). In Finland, sexual education is usually incorporated into various obligatory courses, mainly as part of biology lessons (in lower grades) and later in a course related to general health issues (Wikipedia, Free encyclopedia). Sex education in France has been part of school curricula since 1973, schools are expected to provide 30 to 40 hours of sex education, and pass out condoms, to students in grades eight and nine (UNESCO Courier).

In the Netherlands it is subsidized by the Dutch government, the "Long leve de liefde" ("Long Live Love") package, developed in the late 1980s, aims to give teenagers the skills to make their own decisions regarding health and sexuality. Nearly all secondary schools provide sex education as part of biology classes and over half of primary schools discuss sexuality and contraception (The Dutch model UNESCO Courier 2007). In Sweden, sex education has been mandatory part of school education since 1956. The subject is usually started between ages 7 and 10, and continues up through the grades, incorporated into different subjects such as biology and history and in Switzerland, it has been there since 1950s. Interventions in primary schools were started more recently, with the objective of making children conscious of what is and isn't allowed, and able to say "No".

Sex educationin Poland has never actually developed. At the time of the People's Republic of Poland, since 1973, it was one of the school subjects; however, it was relatively poor and did not

achieve any actual success. After 1989, it practically vanished from the school life-it is currently an exclusive subject (called*wychowanie do zycia w rodzinie/family life education* rather than *edukacjaseksualna/sex education*) in several schools their parents must give consent to the headmasters so that their children may attend. It has much due to the strong objection against sex education of the Catholic Church; the most influential institution in Poland. It has however, been changed and since September, 2009 sex education will become an obligatory subject in the number of 14 per school year – unless parents do not want their children to be taught. Objecting parents will have to write special disagreements (o seksieobowiazkowo w szkole, 2009).

In Egypt they teach knowledge about male and female reproductive systems, sexual organs, contraception and STDs in public schools at the second and third years of the middle-preparatory phase (when students are aged 12-14). A coordinated program between UNDP, UNICEF, and the ministries of health and education promotes sexual education at a larger scale in rural areas and spreads awareness of the dangers of female genital mutilation (UNICEF, 2004).

For the majority of young South Africans, sexual activity starts in the mid-teens. Based on the most representative studies, it is reasonable to conclude that the national average age of the most representative, it is reasonable to conclude that the national average age of first intercourse is 15 years for girls and 14 years for boys. There is however, great variability around these figures. Significant numbers of young people have their sexual debut well before age 14, while many are virgins at age of 18. Boys start to have sex significantly earlier than girls do, and in greater numbers. However, adolescents' knowledge on reproductive function and sexuality is generally poor. A substantial number of young people have indicated that they need information on matters such as pregnancy, STDs, sexual intercourse and relationships.(Ladh andTetteh, 2000).

In Senegalese study, 4% of adolescent women and 7% of adolescent men surveyed have ever visited a family planning clinic. Reasons cited for non-use of services include unmarried status (among women), embarrassment, cost, poor reception by clinic staff, lack of knowledge about sexuality, concern about the efficacy and side effects of contraceptives, and contradictory social perceptions around premarital sex and contraceptive use (Nare, Katz and Tolley, 2006).

Nigeria has taken a number of important policy steps to support youth reproductive health care which includes: The government formulated and launched a national youth reproductive health

policy, reproductive health is on the concurrent legislative list in Nigeria, and, therefore , the three tiers of government, including the states and local governments, are expected to formulate independent policies to guide their programs and service delivery and in 2002, the Federal ministry of Education approved the teaching of sexuality and life planning education in the secondary schools.This policy directive paved the way for development of a national curriculum, recently approved after extensive stakeholder review and debate (Rosen, Murray and moreland, 2004).

In Tanzania, then School Health Education Program (SHEP) reaches16,000 students in 35 secondary schools with a school-based campaign to mobilize young people against HIV/AIDS. Involvement of the wider community has been a critical program element, yet one that program officials see as demanding and time-consuming (World Bank, 2003).

In Kenya reproductive health needs for most youths in secondary schools and out of school focused on promotion of responsible sexual behavior. Youths in schools are reached through family life education, components of which are integrated in carrier subjects (GoK, 2004). Peer education programmes are also being implemented in some schools across the country by Kenya Adolescent Reproductive Health Project (KARP) (Askew, Chege, Njue and Radeny, 2004), Rapado, Aphia Plus among others. These programmes provide youth with life saving skills they need to protect themselves from unplanned pregnancies, STI/HIV/AIDS. Reproductive health education needs for youth out of schools are provided at youth friendly clinics and at youth centers established in some districts within the country. Call-in weekly programmes targeting the youth are also aired on the national radio that is for Kenya case citizen radio station (Tijuana et al., 2004). Despite these efforts, newspapers, periodicals, journals and magazines often carry sensational stories of teenage sex escapades, pregnancies, sexually transmitted diseases like gonorrhea, syphilis and herpes among youths in schools (KDHS, 2008-2009 and Fabiyi, 2005), most recently (relatively) but more dangerous are the reported cases of Acquired Immune Deficiency Syndrome (HIV-AIDS), while the reports of expulsion of pregnant students by school authorities are also common, just to mention, in Kwale County it was reported that a 14 year old girl has been living in agony after she was involve in love affair with a teacher who impregnated her, the girl is traumatized after the teacher forced her to abort. When the teacher got the wind that the girl is pregnant, the teacher gave her a pill and after a few hours she started

bleeding. For two weeks since the abortion ordeal, the bleeding has not stopped despite her mother taking her to hospital. The girl admitted they had an explicit affair with the teachers but the parents of the girl declined to give further information they had been compromised by the teacher (Standard Newspaper, March, 25, 2012). Most recently (relatively) but more dangerous and disturbing is that one in eight teenage deliveries are by caesarean section, which indicates complicated births, and highlights the risk that adolescents place themselves at becoming pregnant at such an early age and reported cases of Acquired Immune Deficiency Syndrome (HIV/AIDS), while the reports of expulsion of pregnant students by school authorities are also common (Momodu, 2008).

Across the district during the prize giving ceremonies, district education days and chiefs' barazas, teenage pregnancy is a matter that is highly talked about, school drop outs among girls and some attempting abortions, to add salt to the wound some teenage girls have been diagnosed with HIV/AIDS and they are not ready to take the ARVS, they are highly stigmatized. It is upon this background that factors influencing implementation of reproductive health education in public secondary schools in Uriri District of Migori County to be investigated.

1.2. Statement of the Problem

The governmental and non-governmental efforts to reduce the spread of AIDS, the incidence of HIV/AIDS and sexually-transmitted diseases among youth in Uriri District- especially girls- does not seem to be abating (KAIS, 2012). Moreover, the rates of unintended pregnancies and unsafe abortions among the girls in Uriri district are very high (Uriri District Education Report, 2012). The rate of disease transmission and unwanted pregnancies among these youths continue to rise despite implementation regarding youth sexuality and contraception, life skills that enable them to resist peer pressure and asserting themselves and accessibility of appropriate sexually transmitted diseases and contraceptive information and services among others. Many youths/ adolescents are still vulnerable and still suffer from the consequences of coerced, undesired and/or unprotected sex. It is upon this backdrop that factors influencing the implementation of reproductive health education in public secondary schools in Uriri District, Migori County would like to be investigated.

1.3. Purpose of the Study

The purpose of this study was to investigate the factors influencing implementation of reproductive health education in public secondary schools in Uriri District of Migori County.

1.4. Objective of the Study

1. To establish the extent to which school curriculum influence implementation of reproductive health education in public secondary schools in Uriri District Migori County.

2. To determine the extent to which school management influence implementation of reproductive health education in public secondary schools in Uriri district of Migori County.

3. To investigate how teachers influence implementation of reproductive health education in public secondary schools in Uriri district of Migori County.

4. To establish the extent to which resource materials influence implementation of reproductive health education in public secondary schools in Uriri District of Migori County.

5. To determine how the school sponsors influence implementation of reproductive health education in public secondary schools in Uriri District of Migori County.

1.5. Research Hypotheses

$Ho_{1.}$ There is no significant relationship between school curriculum and implementation of reproductive health education in public secondary schools in Uriri District Migori County.

$Ho_{2.}$ There is no significant relationship between school management and implementation of reproductive health education in public secondary schools in Uriri District Migori County.

$Ho_{3.}$ There is no significant relationship between teachers and implementation of reproductive health education in public secondary schools in Uriri District Migori County.

$Ho_{4.}$ There is no significant relationship between resource materials and implementation of reproductive health education in public secondary schools in Uriri District Migori County.

Ho_{5}. There is no significant relationship between school sponsors and implementation of reproductive health education in public secondary schools in Uriri District Migori County.

1.6. Significance of the Study

This study may help students acquire health education knowledge, enhance wellness behaviors, promote health situations, facilitate healthful relationships and enable students make responsible decisions. Health instruction help learners to develop resistance skills when appropriate, promote protective factors, ensure resilience in terms of the ability to prevent or to recover from sickness and to promote health literacy if implemented by competent instructors, since students are brought up now days in societies and families in which domestic violence and drug or chemical dependency are the rule rather than the exception. The study may also give governments' good return on investments from improved health and reduced medical cost. There are also economic benefits of averted HIV infection and benefits of other potential program outcomes such as increased education, reduced STIs, and reduced teen pregnancies and abortions.The study may make teachers, parents and students alike more comfortable with their bodies, and so more able to communicate wishes to others including safer sex, and to resist coercion, this is a public health benefit. Lastly the study may help teachers develop confidence to the teaching of sexuality issues and that they had also learnt skills in their negotiations for safer sex.

1.7. Limitations of the Study

Mutai (2000) defines limitation as the limiting conditions or restrictive weaknesses. These conditions are beyond the control of the researcher and may place restrictions on the conclusions of the study and their applications to other situations. Mugenda and Mugenda (2003) posit that it is an aspect of research that may influence the results negatively but over which the researcher has no control. In this respect the research would experience potent effect of non- response, error or the potential of substituting a sampling unit in the field because the respondents who are the students might have been sent home for fees, or might have been out the school for half-term holiday and this might affect the accuracy of the results. In this case the researcher would carry out the data collection at appropriate time when all students are at school. The school management and teachers might bring the issue of call later on; the researcher would elaborate the content of the questionnaire to the management and teacher respondents for him or her to appreciate the importance of him or her filling the questionnaire or taking part in the research. There would be the problem of both sampling and non-sampling errors, this would affect not only accuracy and precision of results but also the scope of the interpretation, to counter this

problem the researcher would perform complete census in selecting the schools and simple random sampling in selecting the particular respondents in the secondary schools. The sample respondents that are the students, teachers, school management, and school sponsors are engaged in many activities which are inter-twined, inter-related and inter-dependent. The interaction of these various influences may not be understood sufficiently thus the researcher would strive to elaborate the research topic to give the whole picture of the study. Last but not least the time and resources scheduled for this study are limited hence even though every effort will be made to cover crucial aspects associated with the research problem; it is not possible to cover each and every aspect of issues in the field.

1.8. Delimitations of the Study

The study was basically concerned with factors influencing implementation of reproductive health education in public secondary schools in Uriri District, Migori County. It was delimited to all public secondary schools in Uriri District. The District is cosmopolitan in the sense that it has not only very many tribes and clans but also it is peri-urban area. It has sixteen (16) secondary schools with very high student populations since schooling is compulsory for children aged between six or seven years and seventeen years or so (Smith, Kippax and Aggletton, 2000). The study would also be delimited to 115 teachers since they are the gatekeepers of knowledge and skills for the large majority of young people (Tijuana, et al, 2004). The research would also be done on the school administrators/ management who include principals and deputy principals (31) since entry to school by the non-governmental organizations/reproductive health provider is at their behest. The data of the study would be collected through use of questionnaires since all the respondents are literate. It would be conducted through descriptive research survey technique.

1.9. Basic Assumptions of the Study

It was hoped that the respondents would cooperate with the researcher and the questionnaires would be filled. The school administrators would allow the teachers and pupils to participate in the study. The sample was representative, the instruments valid and reliable and the respondents were to give information honestly and directly.

1.10. Definitions of Significant terms as used in the Study

Reproductive Health Education: This is education which encompasses education about all aspects of sexuality including information about family plan reproduction (fertilization, conception and development of the embryo and fetus, through to childbirth), plus information about all aspects of one's sexuality including: body image, sexual orientation, sexual pleasure, values, decision making, communication, dating, relationships, sexually transmitted infections (STIs) and how to avoid them, and birth control methods.

Learning/ Teaching materials: These are materials which are used by those providing the reproductive health education or sexuality education. They include videos, text books, films, handbooks and pamphlets.

Resource persons: These those persons who are offering the sexuality education to the students they include teachers, the students themselves and other individuals invited to the school to offer talks related to sexuality education for example persons from NGO dealing with reproductive health or HIV/AIDS related issues.

School Management: This would compose of the school principal, the deputy principal.

School Sponsor: This would be a representative of the church who is in contact with the school in its day to day activities.

Public Secondary Schools: Those secondary schools run by the Government of Kenya

1.12. Organization of the Study

The study started with introduction which contains the background information of the study, statement of the problem of the study, purpose of the study, objectives of the study, research hypotheses, significance of the study, limitation of the study, delimitation of the study, basic assumptions of the study, definitions of the significant terms as used in the study and organization of the study.Then there was literature review which was contained in chapter two of the study and it was opened up by an introduction followed by theoretical framework succeeded by conceptual framework of the study and finally summary of the literature review closes the chapter. The last content was research methodology of the study contained in chapters three, it was introduced, and then the following sub-topics follow each other respectively research design, target population, sample size and sampling procedures, research instruments, data collection procedures, data analysis techniques, and operational definitions of the variables. Then the data analysis, presentation, interpretation and discussion were contained in chapter four of the study. Last but not least there was chapter five which had summary of the findings, conclusions and recommendations for further study.

CHAPTER TWO

LITERATURE REVIEW OF THE STUDY

2.1. Introduction

This chapter discusses the literature related to the factors influencing implementation of reproductive health education in secondary schools in Uriri District, Migori County. In particular it would focus on school curriculum since reproductive health education curriculum is not examinable, so the school might be focused on the examinable curriculum. School management, they are the overseer of the curriculum implementation in the school. Teachers are normally the gate keepers of knowledge in school and they are the main implementers of the reproductive health education in school.Resource materials, without teaching-learning resources implementation of reproductive health education becomes futile and school sponsors do interfere with the implementation of reproductive health education in schools as there have been a tussle between the church and the state as most schools affiliated to church. And how the variables so far described influences the implementation of reproductive health education in the secondary schools.

2.2. The Concept of Reproductive Health Education

Traditionally, adolescents were not given any information on sexual matters, with discussion of these issues being considered taboo. Such instruction as was given was traditionally left to a child's parents, and often this was put off until just before a child's marriage. Most of the information on sexual matters was obtained informally from friends and the media, and much of this information was of doubtful value. Much of such information was usually known to be deficient, especially during the period following puberty when curiosity of sexual matters was the most acute. This deficiency became increasingly evident by the increasing incidence of teenage pregnancies, especially in Western countries after the 1960s. As part of each country's efforts to reduce such pregnancies, programs of sex education were instituted, initially over strong opposition from parent and religious group (Wikipedia, the free encyclopedia). Base on this, the World Health Organization (WHO) and other intergovernmental, international, and bilateral organizations made a commitment to promoting the principles of reproductive health at the international conference on Population and development in 1994. Specific aspects of

reproductive health endorsed included the ideas that prevention of unintended pregnancies must be given the highest priority, and that every attempt should be made to eliminate the need for abortion include freedom from risk of sexually transmitted diseases, the right to regulate one's own fertility with full knowledge of contraceptive choices, and the ability to control sexuality without being discriminated against because of age, marital status, income, or similar considerations (United Nations 1995). But efforts to promote reproductive health should not be limited to girls/ women-boys/men should also be involved.

The Cairo programme of 1994 acknowledges that particular attention needs to be given to the reproductive health needs of adolescence as a group, as previously their need for reproductive health services had largely been ignored. To rectify this situation, the programme called on governments to make accessible to young people information and services on sexuality and how to protect themselves from unwanted pregnancies and sexually transmitted diseases (UN 1994).

The five-year review of the Cairo programme of action (ICPD +5) states that in order to protect and promote the right of adolescents to the enjoyment of the highest attainable standards of health, provide appropriate specific, user-friendly and accessible services to address effectively their reproductive and sexual health needs, including reproductive health education, information, counseling and health promotion strategies. These services should safeguard the rights of adolescents to privacy, confidentiality and informed consent respecting their cultural values, and religious beliefs and in conformity with relevant existing International agreements and conventions (www.UNFPA, paragraph 73a).

The world today is experiencing an unprecedented increase in the number of young people. One in every five persons in the world is a young person. Of an estimated 1.2 billion young people in the world today, 85% of these live in developing countries. The world Health Organization has defined adolescents as persons in the age group of 10-19 years, while "youth'' has been defined as the 15-24 years age group (WHO, 2006). These two overlapping groups have been combined into one entity that of "young people'' as those in the age range 10-24 years (WHO, 2006). WHO defines health as a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity? In the context of this definition, reproductive health is a condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being-not merely the absence of disease or disorders of the reproductive

system. Reproductive health implies that apart from the absence of disease or infirmity, people must have the ability to reproduce, regulate fertility, and enjoy sexual relationships. It further implies that reproduction be carried to a successful outcome through infant and child survival, including growth with healthy development (Fathala, 1997). This reproductive concept is not limited to girls or females of childbearing age. It recognizes that the special health needs of adolescents, both females and males, girls and boys, are related to their acquisition of sexual and reproductive health capacity. It asserts further that males/boys need to be educated about sexuality issues including the knowledge and utilization of contraceptives and the need to report early signs of sexually transmitted diseases for prompt treatment (WHO, 2006).

The Healthy development of children and adolescents is influenced by many societal institutions. After the family, the school is the primary institution responsible for the development of young people in the society. Schools have direct contact with more than 95 percent of our nations' young people aged 5-17 years, for about 6 hours a day, and for up to 13 critical years of their social, psychological, physical and intellectual development. Equally schools play an important role in improving students' health and social outcomes, as well as promoting academic success and that is why they have long been identified as appropriate environments in which to undertake activities to promote HIV-related risk reduction among young people. Given that in the majority of countries young people between the ages five and thirteen spend relatively large amounts of time in school, school environments can also provide resource-efficient access to large numbers of young people from diverse social backgrounds (Smith, Kippax and Aggleton, 2000). School as (Lloyd, 2004) puts it is an institution outside the family that plays the most important role in the socialization of the young, has the potential to influence directly students' aspirations, motivation and risk taking behaviors.

Limited access to education and to economic resources characterizes the lives not only of women but also of young people of both sexes. Young people's limited access to resources gravely undermines their health and healthcare-seeking behavior. Most young people are aware of the dangers of HIV/AIDS but continue to be involved in sexual behaviors that place them at high risk of contracting the disease (Hulton, Cullen and Khalokho, 2000). There is also a growing body of evidence confirming that in many countries; most young people do not routinely seek appropriate sexual and reproductive health information and care. The overburdened and under-

financed public health and education systems that are in place are often unable or reluctant to provide such services-let alone high-quality services- to young people (Kiapi and Hart, 2004).

Advocates worldwide recognize the need to address the political and social context in which young people make decisions about sex and reproduction. Globally, commitment to meeting youth reproductive needs has never been higher. International Conferences and agreements such as the 1989 convention on the Rights of the Child, the 1994 International Conferences on Population and Development (ICPD), the U.N. World Program of Action for Youth to the year 2000 and Beyond, and the 2001 U.N. General Assembly Special Session on HIV/AIDS have affirmed the needs of young people for information, counseling, and high-quality sexual and reproductive health services. Therefore Sexuality and reproductive health education is one of the most important and widespread ways to help young people improve their reproductive health. Against the background of these international agreements, to which most countries both developed and developing are signatory to, governments of these countries have organized sexuality education programs of one type or another. Such programs, if thoughtfully designed and well implemented, can provide young people with a solid foundation of knowledge and skills (Rosen, Murray and Moreland, 2004).

Sex education in Africa has focused on stemming the growing AIDS epidemic. Several statistics show that in sub-Saharan Africa, about 14 million unintended pregnancies occur every year among the adolescent youths, with poor use of the short term hormonal method being responsible for measurable proportion of this (IPPF, 2009). Many of this unintended pregnancies end up in unsafe abortions and deaths, pushing up the maternal rates of these African countries. Among teenage girls, unintended pregnancies carry a higher risk of obstetric complications such as fistula and obstructed labor, making them twice as likely to die compared to women aged over 20 years. In Zambia, according to the 2007 Zambia Demographic and Health Survey, 28 percent of the girls aged 15 to 19 had begun child bearing, 22 percent had child and 6 percent were pregnant with their first child by the time of the survey. An estimated 35 percent of teenagers in rural areas had begun childbearing compared with teenagers in urban areas (22 percent). More than 75 percent of these pregnancies were unintended.

Agnes Binagwaho, permanent secretary in the Ministry of Health in Rwanda stated that young people are assumed to enjoy a robust health given the low mortality rates among adolescents.

This perception has led to a serious neglect of adolescents in the health care system with potentially dangerous consequences: adolescents and young adults often engage in a range of behaviors that can affect the quality of their health and the probability of their survival in the short-term, as well as in the long-term. She highlighted further that certain health conditions are more common for young people and can have devastating and long-lasting effects (Binagwaho, 2009). These according to World Bank and WHO can be grouped into the following categories, with the first five accounting worldwide for about 80% of DALYs for young people (World Bank and WHO, 2006): Reproductive health (e.g. unmet family planning needs, early unwanted pregnancies, unsafe abortion, etc.), STIs including HIV/AIDS, Mental health (e.g. psycho-social problems, suicide, self-inflicted injuries), Substance abuse (Legal and illegal substances), Accidents and Injuries and Other health issues

Binagwaho asserts that improving the health of young people is complex and difficult, arguably more so than for other age groups. Compared with children, adolescents are less protected by their families and communities and less amenable to simple solutions to their health problems, many of which are behavior-based. Compared with adults, adolescents often know less about how to stay healthy and have fewer resources to prevent or treat health problems (Binagwaho, 2009). However, their behaviors are less firmly entrenched, and they are often involved in institutional activities, such as schools and training programs where programs with high coverage can be successfully implemented and sustained. And according (Neema, Nakanyike and Kibombo, 2004) school environment programmes normally aims to make the school environment in both primary and secondary schools safer and more supportive of adolescents' reproductive health.

Many of the factors associated with less risky health behaviors go far beyond the purview of the health sector alone. Solutions for adolescent health will have to be based on multi-sectoral approaches that link health sector interventions with other types of interventions delivered through other sectors. Accumulated experience, backed by an increasing body of research, has created international consensus around a multi-intervention approach centered on the following (World Bank, 2006):Young people need information and skills to make the right decisions about behaviors that affect their health, such as whether and when to have sex and whether to use

tobacco or drugs and Young people need access to a broad range of health services that give them the means to act on their knowledge, including access to condoms and other contraceptives.

Young people need a social, legal and regulatory environment that supports healthy behaviors and protects them from harm.Young people are at risk from a broad range of health problems. The major causes of death, disability, and disease among young people in developing countries. They are at risk of physical and psychological trauma resulting from sexual abuse, gender-based violence, and other forms of physical violence and accidents. Other important health needs are sexual and reproductive health disorders; among these are sexually transmitted diseases (STDs), HIV/AIDS, unwanted pregnancies, and pregnancy related complications.

2.3. Curriculum of sexuality Education in Schools

In U.S.A. the studied topics in reproductive health education are; methods of birth control and infection prevention, sexual orientation, sexual abuse, and factual and ethical information about abortion, varied more widely (Family Planning perspectives 32 (5) September/October 2000). According to study by Kaiser family Foundation of 2004 it found out that nearly nine out of ten (89%) of the nation's nearly 20 million public secondary school students take sex education at least once between the 7th and 12th grades yet what students learn vary according to states. The study stated further that across the nation, states have passed a patchwork of sex education laws, ranging from general mandates that the subject be taught to more specific guidelines regarding topics or message to be included. The Aids epidemic led a number of states to pass specific requirements to provide some form of education about the prevention of HIV/AIDS in particular and / or sexually transmitted diseases (STDs) in general. Because most state laws governing these topics are fairly broad, the specific content of the curriculum is often left to local school districts or individual schools. The federal government's involvement in sex education has primarily been to provide funding for education programs. Only two forms of sex education are taught in American schools; ''abstinence plus" and "abstinence only". Comprehensive or "abstinence plus" sex education curricula covers abstinence as a positive choice, but also teaches about contraception and avoidance of STIs when sexually active. Sometimes a comprehensive curriculum may be referred to as "abstinence plus" because it teaches abstinence as the preferred choice. Advocates of comprehensive sex education argue that while young people should be taught to remain abstinent until they are emotionally and physically ready for sex, information

about birth control and disease prevention is essential for those who are sexually active, SEICUS (2008). Abstinence-only sex education teaches abstinence until marriage as the only option for teenagers. Proponents of abstinence-only education argue against any discussion or education about contraception and safer sex, asserting that this sends young people a mixed message that contradicts the absolute prescription of abstinence-thus encouraging sexual activity (http://www.frc.org/infocus/if95k2ab.html). A 2002 nationwide survey conducted by Kaiser Family Foundation and World Population Foundation found that some form of sex education is taught in the vast majority of public secondary schools (95%). Most principals -58% describes their sex education curriculum as comprehensive that is "young people should wait to have sex but if they do not, they should use birth control and practice safe sex". A third (34%) say their school's main message is abstinence-only that is "young people should only have sex when they are married". And within the last decade, federal governments have encouraged abstinence –only education by steering over a billion dollars to such programs. Some 25 states now decline the funding so that they can continue to teach comprehensive sex education. Funding for one of the federal government's two main abstinence-only funding programs, Title V, was extended only until December 31th, 2007: Congress is still debating whether to continue it past that date (www.statesmans.com).

There is continuing debate about the content of HIV and AIDS-related education programs and how and in what manner they are delivered to school students. It is generally agreed that HIV/AIDS education material should include information on: the nature of the virus, its modes of transmission, the consequence of infection, and the steps that can be taken to protect against infection. More contentious is the inclusion of education relating to interpersonal sexual relations and drug use. In this regard, discussion of the avoidance of disease by the use of condoms or the supply of clean needles and syringes can be particularly problematic (Smith, Kippax and Aggleton, 2000).

In the report of HIV and Sexual Health Education in primary and secondary schools(Smith, Kippax and Aggleton, 2000) explained that within the school curriculum, dealing with HIV/AIDS- particularly aspects concerned with the prevention of HIV-transmission-is complex. Dominant cultural understandings influence the manner in which HIV/AIDS can be talked about, for example, drugs are illegal in many countries and are therefore presented to be shunned and

avoided. Sex presents more of an immediate challenge to educators; there being heated controversy, for example, about how sex education should take place and by whom it should be delivered. They further explained that HIV/AIDS is normally contained within subject areas such as science and biology, the links between it and broader social concerns are likely to be left unexplored. Indeed where HIV/AIDS is positioned as a 'problem' for science, discussion of interpersonal sexual relations and drug use may be downplayed. On the other hand, where HIV-prevention is addressed as an important aspect of HIV/AIDS education, interpersonal and social concerns are likely to come to the fore. Where pupils and learners have the opportunity to influence the structure, pacing and issues that are addressed in HIV and AIDS-related education, their everyday anxieties, concerns and experiences are more likely to be addressed.There are also differences of opinion regarding mode of delivery, for example, over whether HIV/AIDS and related issues should be addressed via knowledge-based models or via interactive and skills-based modes of learning. Should HIV/AIDS related health promotion be taught didactically, as a set of 'facts' or should the discussion of HIV- prevention is more effective if linked to the practices of the everyday lives of students, some educators have promoted skills-based and student –centered models, while others preferred a knowledge based and more didactic.

A number of aspects of country policies are worthy of note. All recognize the importance of informing school students about HIV/AIDS transmission and its attendant risks. Knowledge of HIV and ways of avoiding infection is considered important. The responsibility for imparting this knowledge is generally located across a number of subject areas and HIV/AIDS education is typically integrated into existing subjects such as biology, science, and health. It is also the case that HIV and AIDS education is often positioned within a broad moral and ideological framework (file:///C/My Documents/www/website/Asia-Pacific.htm).

Curriculum documents of various countries indicate that most governments deliver some form of sexual and reproductive health education to students at some stage in their history of schooling, although the education that is provided differs greatly between countries in terms of content, depth and reach. The education most students receive in most countries is focused upon the biology of sexual reproduction and not upon sexual practice in social context. Where sex is discussed in social terms, the family usually frames it. These emphases are reflected in the titles given to HIV/AIDS and sexual and reproductive health education programs. For example, in

Malaysia such work takes place within the context of Family Health Education; in Thailand in Life and Family Education; in Vietnam in Population Education, and in Indonesia and Mongolia in Adolescent Reproductive Health. That 'sex' is not used in curricula titles points to the sensitivity of the subject matter. 'Sex education', therefore, clearly does not describe what most countries do. With respect to the transmission of HIV- most curricula refer to HIV as the AIDS virus and some fail to typically differentiate between HIV and AIDS. When discussing the modes of transmission countries mention the following (Smith, Kippax and Aggleton, 2000): Mother to child (vertical), Blood products, Injectable Drug Users (IDU), Sex

According to findings of the research done by Smith and his colleagues they found out that in most of the curriculum sex is positioned as risky and sex is equated with vaginal intercourse. There is no mention of anal or oral intercourse or other forms of sexual kissing and touching. The danger is that any sexual activity may be taken to be risky for HIV transmission or that only vaginal intercourse will be considered risky. This is because the whole field of 'sex' is implied to be vaginal intercourse, or is not defined. Sexual activity is typically framed as something that should occur between husband and wife and where sex is positioned outside of marriage and reproduction it is nearly always discussed as a 'problem'. For example, in lesson plans from Thailand and the Phillipines sex between unmarried young people and sex with sex workers is actively discouraged. In Thailand numerous lesson plans in one curriculum mentioned young men engaging in sex with sex workers but curiously mentioned condoms once (Smith, Kippax and Aggleton, 2000).

National survey of Australian secondary Education of 2010 revealed that 94% of teachers teach abstinence from intercourse until ready, abstinence until marriage is far less common but still highly likely to be taught (68% of teachers). This result indicates that the adoption of teaching content to cultural and social changes in recent decades. Today, most people do not get married before their late twenties or early thirties. Teaching abstinence until getting married therefore seems less applicable since the age gap between becoming sexually active and getting married is substantial for the majority of the population. The National survey further noted that the topic least likely to be covered in sexuality education is the pleasure of sexual behavior/ activity. More than half the teachers (52%) said they would not cover this topic in their teaching curriculum. However, practical examples such as the Long Live Love Program in the Netherlands

demonstrate that comprehensive programs that accept young peoples' sexual desire as being normal and teaching about mutuality and pleasure in sexual relationships can be very effective.According to Dutch Model *UNESCO Courier* of 2007, nearly all secondary schools in Netherlands provide sex education as part of biology classes and over half of primary schools discuss sexuality and contraception. The curriculum focuses on biological aspects of reproduction as well as on values, attitudes, and communication and negotiation skills. The media has encouraged open dialogue and the health-care system guarantees confidentiality and a non-judgmental approach. Within Europe the Netherlands has one of the lowest rates of teenage pregnancy, abortion and STIs among young people in the world, (Van Loon J., 2003) and the Dutch approach is often seen as a model for other countries. In England and Wales, sex education is not compulsory in schools as parents can refuse to let their children take part in the lessons. The curriculum focuses on the reproductive system, fetal development, and the physical and emotional changes of adolescence, while information about contraception and safe sex is discretionary and discussion about relationships is often neglected (England's Education Act 1996). Britain has one of the highest teenage pregnancy rates in Europe (BBC, News.2009-02-26) and sex education is a heated issue in government and media reports. In a 2000 study by the University of Brighton, many 14 to 15 year olds reported disappointment with the content of sex education lessons and felt that lack of confidentiality prevents teenagers from asking teachers about contraception (Britain *UNESCO Courier*). In 2008 study conducted by YouGov for Channel 4 it was revealed that almost three in ten teenagers say they need more sex and relationships education (Channel 4, 2008).

The main sex education programme in Scotland is *Healthy Respect*, which focuses not only on the biological aspects of reproduction but also on relationships and emotions. Education about contraception and sexually transmitted diseases are included in the programmes as a way of encouraging good sexual health. In response to a refusal by Catholic schools to commit to the programme, however, a separate sex education programme has been developed for use in those schools. Funded by the Scottish Government, the programme "*Called to Love* focuses" on encouraging children to delay sex until marriage, and does not cover contraception, and as such is a form of abstinence-only sex education (Catholics teachers, 2008).

A study by Mbananga examining why the reproductive health information on family planning, STDs, HIV/AIDS, sexuality and reproductive cancers disseminated to communities, youths out of school and youths in school failed to change their sexual behavior, the study revealed that the reproductive health information disseminated to local communities, youths out of school and youths in school in South Africa, particularly impoverished areas, were not understood by residents. In fact, poor understanding of reproductive health information, mainly visual information (health posters) was gross (Mbananga and Becker, 2002). Another finding was that reproductive health information, at development stages, did not take into consideration the norms, values, language or culture of the target community (Mbananga, 2002). The fact that reproductive health information posters were generally misunderstood or not understood at all raises three questions. Firstly, why is reproductive health information not understood by community members when it is developed for them? Secondly, how is a lack of cultural awareness and sensitivity in the development of reproductive health information responsible for misunderstanding? Thirdly, why does reproductive health information fail to change sexual behavior? Again the department of Education has successfully piloted sexuality education programs that incorporate an element of parent education (South Africa Department of Education, 2002).

But a gain in South Africa as noted in the research report of School-Based Reproductive Health Education (SBRHE) by (Varga and Shogwe, 1999) the curriculum used is called "family life education" , and included topics surrounding family members' interactions, family roles and responsibilities, self-esteem and responsibility training, marriage and parenting, conflict resolution, stress management, and sexuality education. The latter was quite comprehensive its coverage of both biological and social aspects of human reproduction and sexuality. Also included were lessons on potentially sensitive issues such as contraception, sexual abuse and incest, and homosexuality; though it was left to teachers' discretion as to which topics were covered. The curriculum made use of both lecture format and inter-active participatory teaching methods such as role-plays and drama. The latest version included lessons for primary school children. In Uganda the programme of sexuality education/reproductive education involves school visits, workshops on sensitization for primary and secondary teachers and school clubs in secondary schools (Neema, Nakanyike and Kibombo, 2004) however, they observed that the challenges all these programs face included an increasing demand for *Straight Talk*programs,

which has not yet been met due to the number of staff available at the foundation; that behavior change is more likely to occur in places where services are available (yet Straight Talk Foundation is not in the business of service delivery); and social objection. Unfortunately, they also noted that some sections of the society still accuse Straight Talk Foundation of "promoting immorality" among young people because they feel, for cultural and moral reasons, it is wrong to have open discussions about sexuality with young people.

The most common adolescent and youth reproductive health problem are early child bearing, STIs/HIV/AIDS and unsafe abortion. Adolescent Reproductive Health Policy is in the process of being formulated but currently reproductive health needs for youth focus on promotion of responsible sexual behavior. Youth in schools are reached through family life education, components of which are integrated in carrier subjects. Peer education programmes are also being implemented in some districts. These programmes provide youth with life saving skills they need to protect themselves from unplanned pregnancies, STI/HIV/AIDS. Reproductive health needs for youth out of schools are provided at youth friendly clinics and at youth centers established in some districts. Call-in weekly programmes targeting the youth are also aired on the national radio. Despite these efforts, reproductive health needs for the youth have not been adequately addressed in Kenya. It should be noted that opposition by religious groups has prevented the Family Life Education to be taught in schools (Thumbi, 2008).

In Kenya HIV/AIDS is taught within science subject and social studies, and it delivered as health education whose content range from hygiene taught in class one, good health in class two, cleaning of latrines in class three and meaning and causes of HIV/AIDS in class four, modes of transmission of HIV/AIDS, stages of development of HIV/AIDSand Prevention of HIV/AIDS in class five, HIV testing in class six, myths and misconceptions on HIV/AIDS, care and support of those infected by HIV/AIDS in class 7 and sexually transmitted diseases and control of HIV/AIDS in class 8 but condom is not named as a preventive measure in the whole curriculum. It is also stated that sex is bad and it is a preserve for the only marriage people.

2.4. School Management and Sexuality Education

This 21st century is a critical time when emphasis is on the prevention of diseases such as HIV/AIDS and other STIs, therefore it is expected that health instruction in schools will be adequately supported by school authorities/administrators/managers. A well structured pattern of reproductive health instruction is an impetus to effective living, health promotion and disease prevention. Studies by (Idehen and Oshodin,2008) reveal that problems associated with the absence of health instruction in schools poses a threat and without their timely resolutions, schools would be unable to provide students with the greatest possible assess to variety of learning let alone equip them intellectually, socially and emotionally. They further reveal that schools administrations are biased about reproductive health instruction. In spite of the seemingly interest of school authorities in reproductive health education, they do not provide an ideal teaching and learning environments, moreover, the schools do not have a developed teaching guide outlining progressive plan for reproductive health instruction. The aforementioned features stated in study above shows that reproductive health education in schools contends with administrative related problems in schools. These findings of studies by Idehen and Oshodin are in support of (Ejifugha, 1999) view that reproductive health education in secondary schools would lack definition due to administrative constraints. These findings also contradict (Shuck Smith and Wood, 1999) claim that administrative factors have little or no influence over reproductive health education instruction. There is evidence from extant literature that reproductive health education curriculum is most apt to function if school administrators provide the necessary materials for teaching. However, the findings of Idehen and oshodin of their study on reproductive health education implementation constraints in Nigerian secondary schools corroborate that of (Udoh's, 1996) initial finding of low level of implementation by school authorities. Reproductive health education is viewed by many school authorities in Nigeria as a weaker form of biology and biology is considered as one of the super science subjects. This also reflects the Kenyan case where the reproductive health education is infused in biology in topics such as reproduction in form three. Studies carried out on the experiences of other country's educational systems, which have since included messages of HIV/AIDs show dissatisfaction with infusion and integration modes. (Kann, et al., 1995) on a study in the US shows that compared to health educators, HIV/AIDS infusion teachers were less likely to be adequately trained, and would not cover necessary topics. Many preferred to focus on the science

and biological aspects and missed out on the more sensitive issues such as prevention. In general, they also spent less time on the subject and failed to utilize available resources and methodological teaching skills. Gachuhi analyses HIV/AIDS education in countries in sub-Saharan Africa and makes a case against infusing and integration preferring curricula where HIV/AIDs and other skills based subjects are taught as individually (Gachuhi, 1999).

Another disturbing finding arising from the study done by (Idehen and Oshodin, 2008) is the period of teaching reproductive health per week, the teachers they interviewed agreed that they found the period for teaching health per week to be inadequate. The absence of an ideal teaching period for reproductive health instruction in the secondary schools will certainly compound the process of health education curriculum implementation. Results of the 1st National Survey of Australian Secondary Teachers of Sexuality Education (2010) revealed that teachers (84%) are positively satisfied with the school support they receive for teaching sexuality education while some teachers (91%) are generally satisfied with the curriculum they teach. Despite this high satisfaction with the teaching curriculum respondents' comments reveal some issues with a lack of guidance and clarity for curriculum planning. "The main issues I see is a lack of resources for curriculum planning, the Vels curriculum is not specific enough about what should be taught at different year level, it has vague statements instead. This makes it difficult to ensure all staff follows unit plans and instead many who are uncomfortable teaching it go off on tangents" A survey respondent. The National survey recommended that there should be recognized legitimacy of sexuality education within the school community, which in turn goes hand in hand with the provision of adequate time and resources. Schools should be supported in following the whole school approach in sexuality education that would allow for more time and room to discuss this important area with students, and offer support where and when needed and in the format that best suits the situation (1st National Survey of Australian secondary teachers of sexuality Education, 2010). In their recommendations (Idehen and Oshodin, 2008) to their work titled 'Factors Affecting Health Instruction in Secondary Schools in Edo State, Nigeria" they categorically stated that school authorities should consider health instruction important in the school systems. Health instruction should be balanced with other instructional subjects in the school for the sakes of fairness, equity and justice which are entranced in the democracy.

According to official Journal of the American School Health association, Vol78/2, Feb 2008 parents have argued to courts that they should be given right to decide what topics to be taught to their children in schools. Courts have rejected this claim distinguishing between the right of parents to decide where to send their child to school and the right of schools to decide upon the actual curriculum. Parental freedoms do not encompass "a fundamental constitutional right to dictate the curriculum at the public school to which they have chosen to send their children. For example, in one particularly strong decision, the ninth circuit Court of appeals held that a parent's right to control a child's education "does not extend beyond the threshold of the school door". It was stated further in the journal that the decision which involved a specific challenge to a school's reproductive health curriculum, provides strong support for school reproductive health education programs. Of course, instructional methods or materials that conflict with constitutional norms are not tolerated. Thus, a school system that condones discriminatory teachings related to protected classes (e.g., ethnic or religious groups) may be required to change its curriculum to avoid unwarranted infringements of rights under the First Amendments establishment and free speech clauses and the Four-teenth amendment due process (and equal protection) clauses. School Health Policies and Programs study of 2006 (SHPPS, 2006) indicated that a successful and well coordinated school health program is characterized by the presence of administrators, teachers, other professional staff, and school board members who view health protection and promotion as an essential part of the school's mission; a school health council composed of school, family, and community representatives to ensure a planning process for continuous health improvement; a school health coordinator responsible for organizing and managing the school reproductive health program; and school staff who help plan and implement a full array of school reproductive health courses, services, policies, and programs.

2.5. Teachers and Sexuality Education

In Switzerland secondary schools (age 13-14), condoms are shown to all pupils, and are demonstrated by unfolding over the teacher's fingers. For this, classes are usually separated into girls-only and boy-only subgroups. Condoms are not distributed, however, except among older adolescents engaged in state-run non-compulsory education (age 16-17) (Wikipedia, the free encyclopedia). In Slovakia Republic the content of sex education varies from school to school, mostly being led by a teacher for a subject which translated to English would be Nature science

(The subject covers biology and petrology). The quality of explanation also varies from teacher to teacher and it is not uncommon that the teacher relies on students asking questions. Classes are usually divided into boys/girls, where girls are usually explained the necessary facts about menstruation and pregnancy. Boys are shown a picture of genitalia anatomy with description and may ask questions. Generally, sex education level in Slovakia is quite poor, though the level actually varies from school to school and reason lies as mentioned above somewhere in the issues of the school or the teacher (Free encyclopedia).

Studies by (Lloyd and Grant, 2005) posit that poor health is the outcome of many forces beyond a young person's control, including the disease environment, family circumstances, and personal vulnerability. However, individual behavior also affects health during adolescence. In particular, unprotected sex and/ or early marriage, which can lead to STIs, HIV/AIDS, and pregnancy, carry many risks for young people, including most immediately the risk of school dropout. In an in-depth study of the role of school quality in school dropout and premarital sex in Kenya, (Mensch et al., 2001) and (Lloyd et al., 2000) found that the attitudes and behaviors of teachers towards their students can affect the likelihood of premarital sex while in school and the likelihood of dropout, particularly for girls. This study, which combined direct observations of teacher and student behavior in the classroom with a community based survey of adolescents and their families, found that girls are likely to engage in premarital sex and also more likely to drop out when they are not treated equitably in the classroom. Thus we would expect that students with better resourced and more supportive families, as well as students doing well academically and receiving encouragement from their teachers would be more likely than others to take steps to avoid the risk of dropout by either avoiding sex, engaging in protected sex, taking steps to terminate unwanted pregnancies before detection, or pressuring their parents to refuse or delay early offers of marriage. Lloyd and Grant also observed that differences in behavior between students and non-students cannot necessarily be assumed to be caused by differences in school exposure and experience, because common individual and family factors may simultaneously encourage school success and the avoidance of risk or early marriage among some, and school failure and risk taking or early marriage among others. Nonetheless, differences in the duration of school exposure and experience between students and non-students are likely to be among the factors influencing the behavior of students and non-students during their teenage years. The mean grades attained by those currently enrolled typically exceed the mean grades attained

among the non-enrolled by 50 percent or more, suggesting the possibility that differences in exposure to the school environment could be important.

Researches by (Varga and Shongwe, 1999) noted with concern that the task of teaching sexuality education was often assigned as a means of punishment to the teacher and is a sad reflection of its perceived lack of importance by school officials, and likely had extremely negative effects on teachers' attitudes and ability- and thus success- in conveying such information to students. The choice of teachers engaged in sexuality and health education (Varga and shongwe, 1999) also illustrates the lack of the school system's endorsement for such efforts. The predominant sentiment among those interviewed was that even if teachers had been well-trained or supported sexuality or life skills education, they would eventually fail due to the unsupportive atmosphere in the school systems and negative attitudes of their superiors; many of whom were said to consider sexuality and health education wasted time compared to examination subjects. The principle of academic freedom which is important in protecting students' rights to learn and teachers' educational practices is always contravened since the teachers are not permitted to transform the prescribed curriculum into something other than what the school intends it to be (official Journal of the American School Health Association, Vol 78/2, Feb, 2008) especially in public schools where state and local school boards exercise a great deal of oversight over the curriculum. Public school teachers do not have broad latitude to teach outside the prescribed curriculum. For example, they may lack authority to assign texts from outside the standard curriculum or to choose their own classroom management techniques or pedagogical methods. Academic freedom does not protect a teacher from limitations imposed by school policy on the nature of biological and sexual education provided to students. (Varga and Shongwe, 1999) further reveal that school-based sexuality education in schools was generally neglected and it became a task left to non-governmental organizations (NGOs) and other agencies which give occasional lectures. Such organizations entered schools only at the behest of school officials, and thus sexuality education from these sources was sporadic and of varying quality. In contradiction of this, according to findings of the National Survey of Australian Secondary Teachers of Sexuality Education by (Smith et al., 2011) teachers used class discussion, information session and small group work when teaching sexuality education. The least common teaching methods on the other hand were inviting an outside speaker, running excursions and other methods, they stressed that teachers seldom or never used these methods and in majority of classes values

clarification, interactive sessions and fictional texts or case studies were used in classroom teaching.

Whether and to what extent sexuality education is taught at a school can be influenced by many factors. Research shows that time constraints within the curriculum, lack of resources and training, and external pressures such as parental and community needs are likely to occur and affect teachers' comfort, confidence and willingness to teach sexuality education (Cohen, Byres, Sears and Weaver, 2001) and (Alldred, David and Smith, 2003). According to 1st National Survey of Australian secondary Teachers of Sexuality Education of 2010 had comments of respondents which demonstrated some of these issues identified such as:

"Most teachers feel uncomfortable with the finer details and do not have the available pedagogical in sexual education".

"A major issue is that Health education is taught by non-trained teachers, and health education is considered a 'filler' subject so there is too much teacher turn over each year and therefore not enough consolidation of health education teaching skills."

''I really enjoy teaching sexuality education and follow VELS but these guidelines are not specific enough for each and every lesson plan whilst allowing for individual class learning needs."In the same survey teachers stated that they are able to teach certain sexuality topicsbecause they are not included in the curriculum and that there was no enough time. Someteachers indicated a perceived lack of training, resources or by management/policy for teaching sexuality education.The National Survey revealed that most teachers did not think that providing young people with information on birth control and safe sex encourages them to have sex (NSAST, 2010). Comforting was that teachers are aware of the importance of teaching about feelings and relationships as a good foundation to help students manage their own sexual health and safety. Same sex issues as a part of sexuality education and therefore should not be excluded from sexuality education at school. According to the same survey it is positive result to note that teachers wished that sexuality education should be officially included in the school curriculum and that it should be part of the mandatory content in health education.

It is essential that teachers are adequately prepared to teach sexuality education confidently and effectively and know how to assess student learning (Smith, Schlich horst, Mitchell, Walsh,

Lyons and Blackman, 2011), noted that most teachers teaching sexuality do not have any trainings and majority of them relied on in-service training to help them prepare for their teaching. With in-service training being specialized on selected topics rather than offering a holistic approach and being mostly provided by external organizations, quality control of training is very difficult to achieve.UNESCO evidently notes that sexuality education is more effective if begun before the onset of sexual activity(UNESCO, 2009). In Australia the average age of first sexual intercourse is 16 years, (Rissel, Richters, Grulich, Visser and Smith, 2003) which implies that some education in the first two years of secondary schooling, if not earlier, would be important and appropriate. On the other hand sexuality education should be continued in years 11 and 12 of schooling in order to support young adults in this stressful and challenging time. Senior high school students commonly report more frequent interactions with romantic partners (Lauren and Williams, 1997). The percentage of adolescent who report having romantic relationships increases during their teenage years with 70% of 17 years-olds having had a special romantic relationship in the previous months (Smetana, Compione and Metzger, 2006). It is in the last years of schooling where students need support in managing relationships and feelings in order to maintain a healthy sexual and successful academic life. (Mulama, 2006) in her conclusion in the report to Africa Regional Sexuality Resource Centre noted that subjects covering topics in HIV and reproductive health education have been embraced in the school curriculum . However, there is evidence that teachers are not able to go beyond cultural taboos of sexuality and teach these topics effectively. This has led to failure of such programmes sometimes simply because teachers have their own biases with regard to teaching sexuality and in some cases add their own values and attitudes when doing so. The success of school based HIV, life skills and reproductive health education is likely to be realized if teachers receive sexuality education. Since the current Kenya secondary syllabus is infused and integrated with selected topics from the field of sexuality, mainly HIV/AIDS and reproductive health which do not comprehensively cover all the necessary themes in sexuality. Mulama said that the responsibility of teaching infused and integrated sexuality messages profession to teachers who have no such training means that the issues may not to be handled competently; and there's the likelihood that they receive less attention. There's need for specialized training on sexuality in for teachers during their trainings or in-service training (Mulama, 2006).

There are different gender socialization processes for adolescent boys and girls in Uganda. Traditionally, discussion of sex and other reproductive health matters between adolescents and adults has been restricted to certain topics and certain people (Neema, Nakanyike and kibombo, 2004). For adolescent girls among the Bantu ethnic groups of Uganda, the traditional channel of communication about sex has been the *senga* (i.e., the father's sister or aunt) (Muyinda H. et al., 2007), while for adolescent boys community elders have fulfilled this role in some settings (Kirumira, 1998). Given the HIV/AIDS pandemic, parental guidance and communication on such issues is mentioned in many countries as an important protective factor. Yet there is little adolescent-parent communication in Uganda today and is largely a function of social and cultural norms prohibiting direct communication about sexual matters between parents and adolescents (Neema, Nakanyike and Kibombo, 2004). The paternal aunt (senga) figure is being revived, especially in the central region of Uganda (Gage, Wolf and Neema, 2002). Some recent initiatives, for instance, by the baganda Kingdom have tried to use the existing structure of the *senga* to improve adolescents' access to reproductive health information and other resources for healthy sexual behavior decision-making and to empower young girls with the skills to say "no" to unwanted sex, negotiate safer sex and delay their sexual debut if they were not yet sexually active

Various international and national organizations have developed interventions aimed at behavior change and service delivery strategies for adolescents. These organizations (and their interventions) include the UNICEF (basic Education, Child Care and Protection, and Adolescent Development), UNFPA, Programme for Enhancing Adolescent Reproductive Lives, the family Life Education Programme, and delivery of Improved Services for Health, which has provided services aimed at improving adolescent use of reproductive health services in public health care facilities. UNFPA- supported NGOs contributed to increasing awareness, motivation and adoption of safe reproductive health behaviors and increased accessibility and utilization of reproductive health services. The goal of the efforts spearheaded by these organizations was to contribute to the reduction of adolescent reproductive health problems including the incidence of HIV/AIDS, other STIs and unwanted pregnancy in Uganda through a multi-sectoral, nationwide scaling up of services (Neema, Nakanyike and Kibombo, 2004).

Studies in teacher training on aspects of sexuality show that it is necessary, urgent as well as effective. Studies cited in (Tijuana et al., 2004) which were carried out in various sub-saharan countries have shown that teacher training on sexuality and HIV which positively impacts on teacher sexual health, attitudes, nurtures positive attitudes on issues of young people's sexuality and revealed major gaps in teacher attitudes, knowledge and practices necessary for the success of the HIV/AIDS and life skills programmes (key components in sexuality education), to be introduced at the time in primary schools and teacher training colleges. In Zimbabwe, (Chifunyise et al., 2002) evaluated a four- year HIV/AIDS education given to teachers in training institutions which was aimed at changing both the teacher's own behavior as well equipping them to teach it once they had graduated. The student teachers reported that they had also learnt skills in their negotiation for safer sex. Studies by (Mulama, SLD Fellow, 2006) indicated that the decision of inclusion or exclusion into educational curriculum is tied up to societal change. She states further that this is a responsive way to curriculum development and can be seen in the way that HIV/AIDS education was included into most curriculums only after it became a threat to human life. (Parker and Aggleton, 2005) cited in their study underscore that indeed societal values play a role in this process as curriculums are expected to have the wider goal of socializing the learners into society. (Rabenoro, 2004) on study conducted in Bestimisaraka region of Madagascar where culturally,'sex' is a taboo subject, shows that this cultural trait affected the sexuality education offered in schools which was widely considered "useless" partly because many dropped out before joining the upper classes where it was taught. Though it was not mentioned in the report, teachers in such a cultural background are likely to be unwilling to cover sexually topics within the classroom freely.(Visser, 2005) on an evaluation in South Africa on the implementation of life skills and HIV/AIDS education found that the programme failed because of teachers' non-commitment, poor teacher- pupil relationships, negative attitudes of teacher about teaching 'sex' as well as the understanding by the teachers that their role was to impart knowledge and not get emotionally involved with the learners. In support of Viser findings an earlier study by (Varga and Shogwe, 1999) indicated that teacher trainings were offered which consisted of half-day seminars provided by doctors or university lectures, and was primarily on reproductive health facts. One former teacher who attended such a seminar described the experience, "They had something like 9 speakers during a day that lasted from 8.a.m. in the morning until 2.p.m. in the afternoon. What can you get from such a packed

timetable? None of them had experience with children or teaching- lots of theory and no practice…..." In their conclusion, (Tijuana et al., 2004) offer that an effective sexuality education, training for teachers has to first have an impact on the teachers before they gain the confidence needed to teach topics they consider sensitive and controversial.

At the Association for the Development in Education in Africa Bi-Annual meeting (ADEA, 2001) which, had the goal of finding which approaches to the teaching of HIV/AIDS education was the more effective, different Ministries of Education in sub-Saharan Africa reported that education systems were paying more attention to developing student training curricula as opposed to the training of teachers to use the curricula which was a recipe for failure. The report recommends the need for policies and programmes to impart requisite skills so that teachers may feel confident to teach about HIV/AIDS and issues of sexuality. The curricula should also be sensitive to socio-cultural settings that the teachers are going to work in. Mulama in her Post-Sexuality Leadership Development Fellowship Report concludes that according to WHO definition of sexual health which describes it as encompassing more than the bio-medical aspects of human health; '…not just the absence of disease, dysfunction or infirmity requires that all the other aspects of sexuality are addressed to all groups where sexuality education is offered (Mulama, 2006). She stated further in her conclusion that teachers are already beneficiaries of other forms of education where partial topics in human sexuality are covered. As a sexual right, teacher trainees have the legal right to comprehensive sexuality education. (Tetteh and Ladha, 1998) had also observed earlier that one of the challenges to the implementation of Life skills and HIV/AIDS Education Programme for secondary schools by Planned Parenthood Association of South Africa (PPASA) is the limited capacity of teachers to implement the programme, with the teachers themselves lacking the life skills they are trying to teach. In filling this skill gap observed by Tetteh and Ladha of 1998 the Department of Health and Education took a joint responsibility for further training, and organized consortiums of local experts to offer programmes and at the end of 1997/1998 financial year, over 9, 000 secondary school teachers had been trained to offer life skills programmes. In support of the above initiative (Varga and Shongwe, 1999) observed that in Natal periodic teacher training initiative took place and were often run in connection with trainers from Natal Provincial Authority but differs slightly in methodology in that according to Varga and his colleague the school principal and 2 teachers were trained. Training periods were short, lasting from a half-day to 3 days. To our surprise the

trainers maintain that such trainings were ineffective due to first, they were too short to be thorough as many teachers lacked basic reproductive health knowledge to be able to teach the subject effectively. Second, and perhaps more important, it appears many teachers were themselves uncomfortable with sexuality-related issues, and the training periods did provide them with sufficient time to overcome personal barriers in this regard, much less be prepared to discuss such topics with students. Other concerns are the teachers given the task of teaching sexuality education and according to a teacher who had been in this programme, "Sexuality education was the responsibility of guidance teachers, junior staff members, or those out of favor with the principal. Guidance teachers were the dumping ground for all unpopular subjects and junior staff members who are often recent training college graduates and who were inexperienced. Varga and Shongwe, further revealed that sexuality were often conducted during school "guidance periods". However, as the topic was not an examinable subject, such instruction was often erratic and lax. One former Natal Province Authority official described the situation, "As the year progressed and things got more harried and time became short, periods which were supposed to be used for sexuality education were neglected in favor of subjects that needed more attention in preparation for examinations. The guidance periods in schools were generally a melting pot issues, and often sexuality education got pushed to the side when higher priority issues came up".

Despite sexuality education beginnings in most secondary schools, the initiatives were not generally sustained and another problem teachers encountered in attempting to teach sexuality and life skills was their inability to handle multiple, and often conflicting roles; to be both academic disciplinarians and friendly facilitators for students' life skills enrichment. Teachers reported being ill at ease with such "role reversals" in the school context, and felt students were also confused by such dynamics (Varga and Shongwe, 1999).

2.6. Teaching and Learning Materials

Whenever there is an outcry of unintended pregnancy or an infection of STIs or a case of abortion, the first question that comes to mind is why was the contraceptives not used in the first place. Such a concern is informed by whether girls and boys have access to contraceptives whenever they need them. And whether they are empowered with appropriate information on how to use them and exercise equal power to make such choices. If these were in place,

unintended pregnancies, STIs infections and unsafe abortion would a thing of the past. According to a 2007 report of a study ordered by the U.S Congress showed that in the U.S. between the years 2005 and 2006 birth rate for teenagers aged 15-19 rose to 3 percent, from 40.5 live births per 1,000 females aged 15-19 in 2005 to 41.9 births per 1,000 in 2006. This follows a 14-year downward trend in which the teen birth rate fell by 34 percent from its all-time peak of 61.8 births per 1,000 in 1991 (http://www.cdc.gov/r071205.htm). This explains why proponents of comprehensive sex education, which include the American Psychological Association argue that sexual behavior after puberty is a given, and it is therefore crucial to provide information about the risks and how they can be minimized; they also claim that denying teens such factual information leads to unwanted pregnancies and STIs.

In the U.S.A. schools must develop and adopt policies (and notify parent of these policies) concerning a parent's right to inspect any instructional materials to be used in the educational curriculum, any survey that will be administered or disseminated by the school, and any instructional materials used in connection with any survey, analysis, or evaluation. Moreover, no student can be required to participate in a survey, analysis, or evaluation funded in whole or in part by educational department that reveals information concerning, among other areas, mental or psychological problems of the student or the student's family or sex behavior or attitudes without prior consent of the student if the student is an adult or an emancipated minor Official Journal of American health Association, 78, No. 2, Feb, 2008). In the same Journal of the American Health Association it is indicated that in the multiyear review of the abstinence only program which was released in the year 2005 (Maynard,et al., 2005) and Government Accountability Office (GAO) report released in 2006 describes the over-sight of federally-funded abstinence-until-marriage education programs specifically on the efforts by Department of Health and Human Services (DHHS) and states to assess the scientific accuracy of materials used in abstinence-until-marriage education programs and efforts by DHHS, states, and researchers to assess the effectiveness of abstinence-until-marriage education programs (http://www.gao.gov/new.items/do787.pdf (last visited October 19, 2007).A survey conducted in Britain, Canada and the United states by Angus Reid Public Opinion in November, 2011 asked adults respondents to look back to the time when they were teenagers, and describe how useful several sources were in enabling them to learn more about sex. By far, the largest proportion of respondents in the three countries (74% in Canada, 67% in Britain and 63% in the United States)

said that conversations with friends were “very useful’ or “moderately useful”. The next reputable source was the media (television, books, movies, magazines), mentioned by three-in-five Britons (65%) and Canadians (62%) and more than half of Americans (54%) as useful. There were other striking differences on two other sources. While half of Canadians (54%) and Americans (52%) found their sex education courses at school to be useful, only 43 percent of Britons share the same view. And while more than half of Americans (57%) say conversations with family were useful, only 49 percent of Canadians and 35 percent of Britons had the same experience (Canseco, Nov, 2011). Sex Education in Texas has been left to the individual districts and the school districts do not distribute condoms in connection with instruction relating to human sexuality (http://www.statutes.legis.state.tx.us/Docs) and according to this senate bill of 1997 it stated that if instruction on contraception and condoms is included in curriculum content then contraception and condom use are suppose to be taught in terms of human use reality rates instead of theoretical laboratory rates. But studies by Drs. David Wiley and Kelly Wilson published the just Say Don’t Know: Sexuality Education in Texas Public schools (http://www.tfn.org/site/Docserver) found that majority of students receive no information about human sexuality except abstinence and the material used regularly contain factual errors and distort the truth about condoms and STDs. In view of these findings Texas State Representative Mike Villarreal, stated categorically that they have a responsibility to ensure that their children receive accurate information in the classroom, particularly when students’ health are at stake, he was further quoted saying that they are dealing with myriad of problems in Texas as a result of their sky high teen pregnancy rates. He asserted that they cannot allow their schools to provide erroneous information-the stakes are far too high (http://www.house.state.tx.us/members). With this in mind, many state legislators proposed bills to improve the sexual education in Texas Schools. These include:SB 852/HB 1624- In February 2011, Senator Ellis proposed The Education Work bill. This bill would require schools that teach sex education to provide evidence-based, age-appropriate information that emphasizes the importance of abstinence as the only 100% effective method of avoiding sexually transmitted infections (STIs) and pregnancy, while also teaching about contraceptive methods to avoid STIs and pregnancy, HB 741/SB 515 – In 2011, Representative Joaquin Castro and Mike Villarreal introduced a bill calling for abstinence-plus sexual health education bill. The bill would have medically accurate information, including: abstinence, contraception, and what it really takes to be a parent. The bill received a

hearing but was left in committee and HB 1567/ SB 1076 – Introduced in 2009 by Villarreal, this bill would have required instruction on contraceptive use to be scientifically accurate when it is taught as part of a school's sexual curriculum. It did not receive a hearing.

In spite of these proposed legal frameworks, catholic schools in Texas follow the Catholic Church teachings in regard to Sex Education. Some opponents of sex education in catholic schools truly believe sex education programs are doing more harm to the young than good. Research shows that sex education in the classroom can be 'dehumanizing and leads to neurosis'. Opponents contend that children are not mentally and emotionally ready for this type of instruction. Exposing the young to sex education programs may foster the students with the preoccupation of sex. These research findings had been contradicted by several studies (state of the World Population report, 1997) and (UNFPA, 1998) stated that immediate investment in adolescent sexual and reproductive health and rights (SRHR) is a valuable step in achieving basic human rights and sustainable development and during the 8th General Assembly Asian Forum of Parliamentarians on Population and Development which was on 12th, November, 2005, UNFPA Director Thoraya Obaid stated that sexuality education is one of the best investments a nation can make a quick win that can go a long way in strengthening the capacity of countries to fight poverty. Family Health International in 2005 also argued that evidence –based comprehensive sexuality education can play a crucial role in supporting young people in their (sexual) development, becoming responsible adults and active citizens; it can help decrease vulnerability to sexual reproductive health problems, including HIV/AIDS; it is crucial for correcting ignorance and misconceptions about sexuality and reproduction. Family Health International team in their report concluded that sexuality education is effective in helping young people to choose for healthy lifestyles; delaying their sexual debut, safer sex and fewer partners FHI Working Paper Series No. WP05-03.2005). An earlier study by (Smith, Kippax and Aggleton ,2000) also in their studies dispute the stand of the catholic church, they noted that social aspects of sexual practice are often not discussed and they illustrated that condoms are most likely to be incorporated into science-based curricula, using the didactic mode of teaching. Typically, condoms do not form part of discussions of interpersonal sexual relations, while interpersonal sexual relations, if discussed at all, and always fall within the skills-based mode of education. They also indicated that when life-skills constitute the mode of teaching about condoms, it is typically as a fallback position when abstinence and fidelity have 'failed' (the

ABC strategy). More importantly they stated that life-skills have the potential to deal with interpersonal sexual relations, but it should be recognized that moral frameworks constrain the ways in which sex can be explicitly discussed. Again during the National Survey of Australian Secondary Teachers of Sexuality Education a teacher who was being interviewed commented that due to early or young start to sexual activity in the local community, young pregnancies and high infection rates for STIs, it is important to provide students with factual, relevant sexuality education programs from early primary schooling through to higher education completion of Certificate of Education (1st National Survey of Australian Secondary Teachers of Sexuality Education, 2010).Also studies by (Dawson, 1997), (Frankham, 1998) and (Gold, 1999) cited in the work of Idehen and Oshodin of the year 2008 reveal the significance of health instruction and they concluded that health instruction is effective in reducing many high-rates among young people. But its overall effectiveness depends on many factors such as the quality of teachers providing health instruction, the available instructional materials in terms of textbooks, pamphlets, posters and other available infrastructural facilities such as play fields, toilets, comprehensiveness of the health education programme, time available for instruction, family involvement and community participation in matters related to health education (Idehen and Oshodin, 2008).

In China and Sri Lanka, sex education traditionally consists of reading the reproduction section of biology textbooks. In Sri Lanka they teach the children when they are 17-18 years. However, in 2000 a new five-year project was introduced by the China family planning Association to "promote reproductive health education among Chinese teenagers and unmarried youth" in twelve urban districts and three counties. This included discussion about sex within human relationships as well as pregnancy and HIV prevention (China Development Brief, 2005-06-03). The International Planned Parenthood Federation (IPPF) and BBC World service ran a 12-part series known as Sexwise, which discussed sex education, family life education, contraception and parenting. It was first launched in South Asia and then extended worldwide (IPPF, 2011). The population and Family Welfare federation in Finland provides all 15-year-olds an introductory sexual package that includes an information brochure, a condom and a cartoon love story (Wikipedia, Free encyclopedia). In January 2000, the French government launched an information campaign on contraception to high school students (UNESCO Courier). In Australia, as per the findings of the National Survey of Australian Secondary Teachers of Sexuality

Education websites and DVDs are the commonly used teaching resources though some teachers also use choice media's DVD 'It's your choice', catholic Education Office documents, contraceptive kits, self-made or self-collected material, guest speakers and textbooks (Smith et al., 2011).In a closer examination of the findings of the National Survey of Australian Secondary Teachers of Sexuality Education by (Smith, Schlichthorst, Mitchell, Walsh, Lyons, Blackman and Pitts, 2011) reveals that time and resources constrain the depth of sexuality coverage. A large proportion of teachers said they teach comprehensive sexuality education but at the same time they admitted needing assistance with the more sensitive and difficult issues including sexual abuse, sexual orientation, communication and negotiation, and dealing with emotional issues. As topics become more personal it seems more assistance is needed in either teaching strategies or teaching material. A serious issue for teachers was that most of the current teaching material was not up to date and did therefore not meet the needs of today's students. Further, since many teachers spent only little time teaching sexuality education (between 1 and 5 hours within a school year and year level) it seems likely that not all the topics that were said to be taught, have been covered thoroughly. For most of the social aspects of sexuality to be taught effectively teachers will need to apply participatory and interactive methods. These methods however take more time in teaching; time that appears unavailable to teachers. In support of this observations, (Varga and Shongwe, 1999) had also observed earlier that most teachers always feel overwhelm by the awareness for the need for sexuality education for students but inadequate resources to provide such information. A former Natal Education Department official described the "panic" with which House of Delegates teachers asked for help. Without official House of Delegates support, she described the Natal Education department's limited means of responding to such requests, "This put us in a difficult position because it wasn't our territory, so to speak. The studies of (Varga and Shongwe, 1999) further reveal that lack of infrastructure and resources are the major obstacles to efforts to offer sexuality education to students and this was summarized in the comment of one of their respondents as, "…When people really started thinking about the issues which came up in the sexuality and life skills courses, many more community problems surfaced-incest, rape, abuse… people started talking about these things…and the worst thing about it was that once they had articulated and realized these problems…they also found they had no resources available to solve these problems. There was nowhere to turn except the misery of helplessness. What good was a life skill if it only made you

more aware of your helpless plight… and the misery of your community? The community just couldn't cope with the workload and was completely unresourced, unable to deal with such responsibilities and problems and their need to be solved".In support of this sentiments studies by (Eke, 1989) and (Idehen, 2004) reveal that most countries that offer reproductive health education or sexuality education, experience improper implementation of the curriculum components due to lack of infrastructureand instructional materials where mainly the problems identified by the researchers are responsible for the poor status of health education in school systems. (Idehen and oshodin, 2008) also recommended that health instruction in schools cannot be adequately carried out without instructional resources. Government and school authorities must therefore help to provide instructional materials, relevant and modern textbooks, pamphlets, posters, computers and other related materials should be provided for students by parents and school management. It is significant to mention that in whatever function one finds oneself, the most important factor is good health, if health is lacking, productivity will be seriously undermined. Thus every health education teacher in Nigeria has the potential for positively affecting the health status of students. Furthermore, many students contend with health problems that influence their ability to learn. For instance, some students are not adequately fed; others lack relevant vaccination and are vulnerable to various infections and diseases such as tuberculosis, measles, meningitis, malaria and infective hepatitis.

In Nigeria, Planned Parenthood Federation of Nigeria estimates that 30 percent of the maternal deaths can be directly attributed to unsafe abortion. It argued that approximately 20 percent of all maternal deaths are estimated to be due to abortion complications and half of these are among school girls (Planned Parenthood of Nigeria, 2008). It is also held that reproduction and sexual activity are both facets of the biological nature of human beings. Although sexual activities are biogenic in nature, how people engage in them is socially determined. A more radical approach holds that no human thought is immune to the ideologizing influences of its social context. For example in South Africa reproductive health information is developed by health professionals who are socially, physically (geographically), culturally and linguistically different from the target population. This information is mainly developed within the strong biomedical model of disease etiology, which is primarily concerned with the cause of disease and reproductive health information is coined using biomedical and health concepts and terminology that are not understood by the target audience. This bio-medical approach to reproductive health information

construction does not consider the culture and lacks relevance and experience of the target audience (Mbananga, 2002).

In Rwanda the Ministry of Education, Science, Technology and Scientific Research (MINEDUC) is conducting a program for HIV/AIDS control called the IEC/STI/AIDS school program that has contributed, among other things, to raising awareness on STIs/HIV/AIDS among school officials (inspectors and directors of primary and secondary schools), pupils during vacation camps and pedagogic facilitators. It also supported the production of teaching aids (training guides, school manuals, various reference documents) and IEC materials (posters, video-cassettes) and to the creation of anti-AIDS clubs in the schools. There are early interventions targeting young people in schools inUganda especially those in secondary schools through school based programs such as the School Health Education Project, Health Education Network and Save Youth from AIDS. These programs focused on integrating HIV/AIDS in school curricula and building the capacity of teachers to handle topics related to HIV/AIDS. Currently programs such as free hotlines, Phone-in radio programs, internet and print media have been initiated, targeted at school-going children. These programs help adolescents get answers about various issues surrounding sex and sexuality in a confidential manner. In addition, several community-based programs have integrated child rights protection awareness into their programs to empower children and their parents to fight child abuse. Strict laws including death penalties for those convicted and proven guilty of sexual abuse have also been instituted (Neema, Nakanyike and Kibombo, 2004).

Ugandan's government aggressively implemented innovative peer-support interventions between 1992 and 1998 mainly in secondary schoolsand tertiary institutions. These programs emphasized the formation of Aids Challenge clubs (which hold interschool debates on HIV/AIDS topics), the provision of youth-friendly information, education and communication materials and the training of peer leaders and counselors. Since 1999, other innovative programs have been initiated such as the programme for Enhancing Adolescent Reproductive Life; the Sara Communication Initiative; the Naguru Teenage and Information Centre; Basic Education Child Care and Protection, and Adolescents Development; and Straight Talk Foundation. (Neema, Nakanyike and Kibombo, 2004) said that these programs enhance youth skills in communication, sexual negotiation, responding to peer pressure and developing positive relationships with the opposite

sex. In addition, the programs help youth to acquire life skills for use in actual situations such as responding to sexual advances, avoiding an attempted rape and making life long development plans. Other initiatives include teaching improved decision making and problems solving with regard to AIDS, sexuality and health. Health services targeting adolescents are often limited to schools. These services include curative services and information, education and communication on growth and development through film shows, plays, seminars and talks. Yet there are other locations of service provision beyond the school. Information, education and communication programs found inschools, health units and religious institutions mainly focus on HIV/AIDS and other STIs, sex education, growth and development, life skills education and behavior change. There are also service being offered by NGOs, churches, and health care providers. Posters, media talks and seminars are used to convey health information to young people.

There was also Straight Talk Foundation communication strategy which targeted in-and out –of –school adolescents. Mass media interventions reinforce the program messages through a weekly 30 minute English-language radio show broadcast on FM stations addressing different adolescent sexual and reproductive health messages including HIV/AIDS. *Straight Talk* (targeting 15-19 –year olds) and *Young Talk* newspapers (targeting 10-14 year-olds) are produced in English every month for the in-school adolescents. *A* Teacher *Talk* newspaper is also produced for primary school teachers to complement teacher training in adolescent sexual and reproductive health and the *Young talk* newspaper. Information, education and communication materials such as posters, newspapers, and other newsprint are access channels.*Straight Talk*and *Young Talk*newspaper supplied by Straight Talk Foundation have targeted in-school adolescents with messages concerning adolescent sexual and reproductive health. Created in 1993, *Straight Talk*circulates on a monthly basis and addresses issues of sexuality, relationships, HIV and other STIs. The newspaper publishes articles by and for young people, features from health-care providers and letters from readers. Videos, films and drama have been used by NGOs, such as AIC and The AIDS Support Organization, and by community health workers are another important information, education and communication medium. Adolescents who go to health centers for treatments are also given sexual health information. Uganda (Nankunda et al., 2003) as a country had several behavior change and communication programs which are for youths in and out of school one of them is the Care and Support Project which was started as a pilot project to address out-of-school youth involved in transient trades who were not being reached with HIV/AIDS

prevention, medical care and psychological/social support. Activities included monthly discussions and home visits on adolescent sexual and reproductive health topics carried out by 30 peer educators, a youth phone helpline and outreach activities from churches every Sunday. Two particular challenges to the programs were that peer educator's need continuous refresher training to strengthen and expand their counseling skills and information, education and communication materials were only available in English, which limited the number of people who could read them. It is also right to note at this point that Ugandans have been lucky because their president, Yoweri Museveni has been well known for his crusade against HIV/AIDS. The Presidential Initiative on Aids Strategy for Communication to the Youth, which intends to improve HIV prevention support to the youth throughout the country by increasing and sustaining HIV/AIDS education for school going youth, has been drafted and debated. Modalities for the initiative are already in place and will be headed by the Ministry of Education. Following this initiative, the Ministry of Health information, education and communication unit, are developing assembly messages related to HIV/AIDS and pregnancy prevention for all government schools. These messages are still in draft and the stakeholders are working on it to come up with a book targeting mostly in school-going adolescents.

2.7. School sponsor and Sexuality Education

Most of the secondary schools in Kenya are broadly sponsored by churches of differing denominations either during their initiation through missionaries or school affiliation to church to provide students with spiritual nourishment. Therefore religion has had a major influence in the field of sexual reproductive health, most notably the US Christian right and the Catholic Church (and to lesser extent Islam). These groups have led what is being described as a "backlash against human rights" and in particular sexual & reproductive rights (Long, 2005), and with significant financial power, have wielded political power and influence. Conservative attitudes towards sexuality have led to US government funding restrictions for services for sex workers, and a promotion of narrow sex education programmes for young people focusing on abstinence only as opposed to more comprehensive approaches, particularly in Africa. The Vatican's stance against contraception has compromised the promotion of condoms for STI/AIDS prevention, although this may be about to change (IPPF News, 23 November 2006). Pro-life movements linked to both have hampered efforts to reduce unsafe abortions. These religious groups have

used concepts of “culture” and “tradition” to oppose sexual and reproductive health (Long, 2005). Angleton and Crewe in review of education related to sexuality portend that inclusion of sexuality education within educational curriculums has had its share of controversy that is in one hand there was arguments that teaching about sexuality leads to ‘experimentation’ and on the extreme end, that since sexuality is central to human life, its learning is necessary for the proper development of human beings. At global levels, the concern is that sexuality education curriculums focus on the physical aspects of ‘sex’ and modern sex practices which are considered western and are being imposed on third world populations. (Alldred et al., 2003) on a study conducted in England found that sex and relationship education (SRE) was regarded with low priority partly because of the anxiety around sex education among parents, governors, teachers and their pupils.

2.8. Theoretical framework

This study heavily rely on a theoretical framework that includes social cognitions specified by (Ajzen’s, 1991) theory of planned behavior, (Bandura’s, 1997, 2000) social cognitive theory and (Berger’s and Lockman’s) theory of subjective world which human beings are biologically endowed to construct and inhibit. The first two theories have proved to provide useful change targets for sexual health promotions especially risk reduction actions e.g.use of condoms. It assumes that behaviors, including sexual behaviors are largely predicted by intentions, but with skills and environmental conditions (barriers) as important moderators. According to them behavioral intentions which the youths normally exhibit and commit risky behaviors are functions of three factors namely attitudes towards the actual behavior, social influences (such as descriptive and injunctive norms, social encouragement and pressure), and self-efficacy expectations (the degree to which a person is convinced that he or she is able to carry out the actual behavior. The theories further postulates that feedback loops that imply that behavior is not only a dependent variable, but also may influence interpersonal processes and personal factors (Kok et al., 1996).

Although some have questioned the utility of such theories for adolescent sexual behaviors-based on the presumption that adolescents engage in unplanned, impetuous sex- the empirical evidence suggests that these cognitions also predict adolescents’ sexual behavior in both Western (Leif et al., 2005) and non-Western countries (Bandawe and Foster, 1996).

Although many theories may contribute to the design of educational implementations programmes (e.g. theories about risk communication, attitude change, and self efficacy improvement), Social Cognitive theory (Bandura, 1986) was used as a point of departure for intervention design in the present reproductive health education implementation. Social Cognitive Theory provides a broad variety of theoretical constructs that are associated with behavior and behavior change, but its basic tenets are that behavior interacts with personal factors and environments (reciprocal determinism), that behavior is largely determine by people's expectations and values regarding the outcomes of the behavior (outcome expectationand expectancies), and people's expectations concerning their self efficacy and self control as regards performing the behavior.Social Cognitive Theory has proved to be a useful and effective framework for designing sex-education programmes, including those targeting HIV prevention (Kirby, 2002). Many, however, have questioned the applicability of such a cognitive behavioral model in cultures and contexts like those of Sub-Saharan Africa, basically because of the importance of cultural factors and societal constraints e.g. talking about sex is a taboo and it is shrouded with death in some communities regarding sexual risk reduction.

The Social Construction Reality Theory indicates that people are socialized into cultural species representing specific communities or societies. They perceive, relate to, process, think about and assimilate knowledge or information or education in relation to their own cultural aspects. People living in impoverished, deprived and underdeveloped areas can construct very rigid subjective worlds because of their environment which is not conducive to change. These people are able to learn and institutionalize knowledge if it is branded within familiarity and cultural relevance of their own. This means that whether people will learn and change their sexual behavior on the basis of reproductive health education or information will depend on the cultural relevance of this education or information to them. Therefore, the Social Construction reality Theory is summoned to testify on whether reproductive health education or information disseminated is constructed outside the reality of the target community or population can be effective or not.

The social Construction of Reality (SCR) theory developed by (Berger and Lockman, 1967) relates neatly to a critical analysis of reproductive health information or education: its development, dissemination, communication, interpretation, understanding and utilization at both institutional and target community levels. As far as (Wisdom, 1973) is concerned, Social

Construction Reality is important because it explores ideas that are central to the course of knowledge, and the relationship between subjective and objective realities. Social Construction Reality appeals to reproductive health information or education analysis due to its inclusiveness of philosophical sensitivity to issues of ontology (the nature of reality) and epistemology (the nature of knowledge; in this instance reproductive health information or education) (Wisdom, 1973). Also, the significant realization of the importance of everyday life (in the context of reproductive health information/education, socio-cultural aspects), a central focus of Social Construction Reality, makes it an appropriate and useful perspective in finding answers to the prevailing problems associated with reproductive health information/education.

Despite criticisms that Social Construction Reality (SCR) is weak in addressing cognitive and emotional aspects of everyday life (Mbananga, 2002), it is agreed that it remains the best approach to the critical review of reproductive health information/education. Social Construction Reality is relevant in this study because it deals with the reality as experienced by youths beyond cognitions and emotion. Both cognitive and emotional aspects of youths / people are determined and influenced by their socio-cultural environment. In the framework of this inquiry, the information in the question is reproductive health information/education. Regarding this study it will focus on aspects of reproductive health education/sexuality education that demonstrates the relevance of Social Construction Reality in understanding why youths/students in secondary schools who have receive the education fail to make sense of the information/education and why reproductive health education/ information disseminated to these youths/students does not change into desirable risk reduction behavior.

2.4. Conceptual Framework

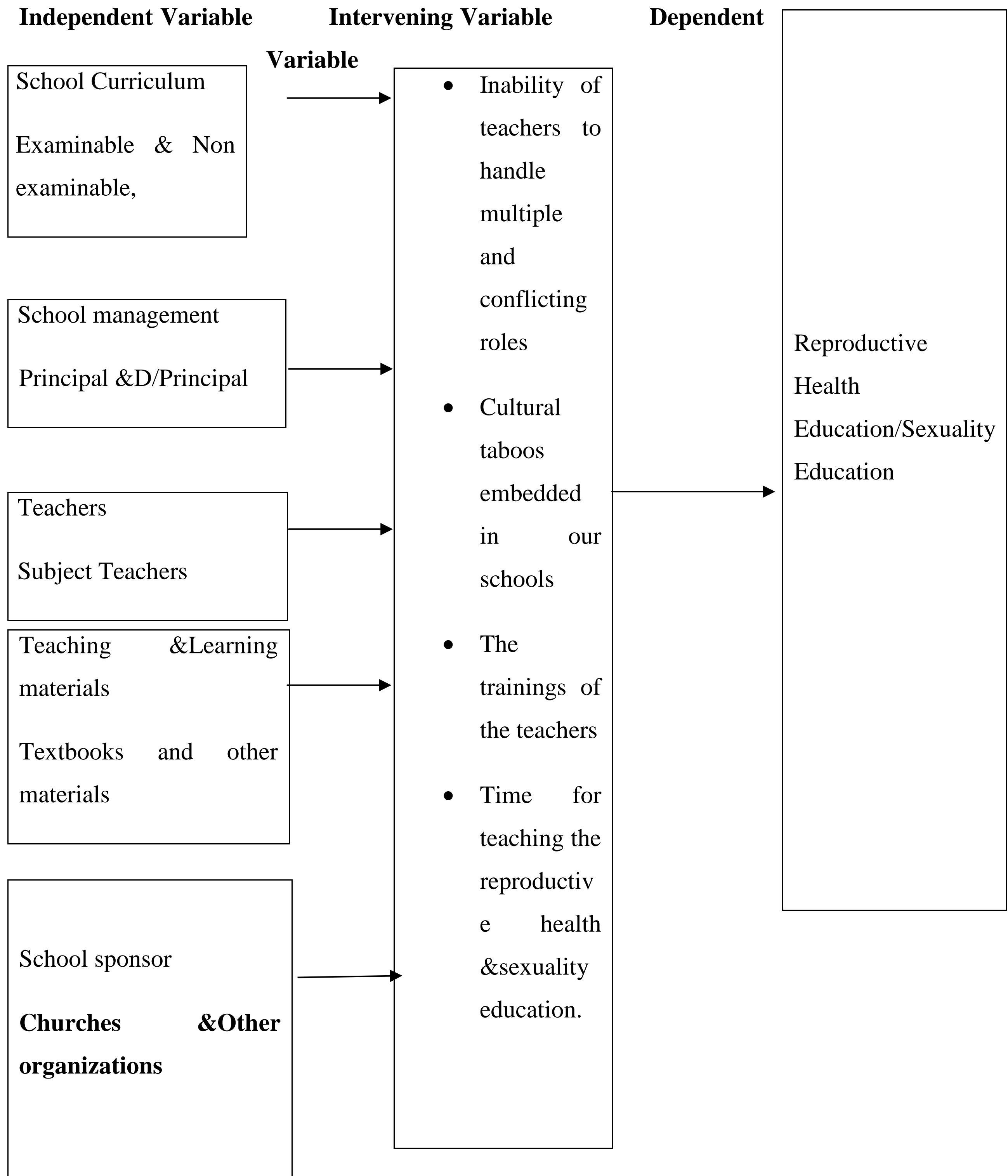

Figure 1.Conceptual framework

2.5. Summary of Literature Review

The literature of past studies related to factors influencing implementation of reproductive health education has been reviewed in relation to school curriculum, school management/administrators, resource persons, teaching and learning materials and school sponsor. The theoretical framework related to factors influencing the implementation of the reproductive health education has been discussed. Finally conceptual framework has been developed; it composed of independent variables, dependent variables, and the intervening/moderating variables. In spite of the several researches that have been carried out to examine the issues and problems pertaining to implementation of reproductive health education, none have attempted to address the role of school managers, teachers, sponsors and school curriculum. Although (Shuck Smith and Wood, 1998) quoted in Idehen and Oshodin work of 2008 had earlier reported that administrative factors have little or no influence over reproductive health implementation in schools. This study is intended to bridge the gap in knowledge about what factors influences the implementation of reproductive health education in public secondary schools in Uriri District and Kenya at large.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This chapter represents a detailed description of research design, target population, sample size and sampling procedures, research instruments, data collection procedures, and data analysis techniques.

3.2. Research Design

This study was conducted through descriptive survey research design method. As per an earlier report by (Bowling, 1999) the survey research enables the collection of detailed and factual information. The survey research also describes existing phenomenon and it also justifies current conditions and practices. The study was concerned with investigating factors influencing implementation of reproductive health education in secondary schools in Uriri district, Migori County. It was specifically intended to investigate how school curriculum, the school management, the resource persons, the teaching and learning materials (resource materials) and the school sponsor influence the implementation of reproductive health education/sexuality education in secondary schools. The design enabled in depth study of the variables to gain more insight in the implementation of reproductive health education/ sexuality education in secondary schools in Kenya.

3.3. Target Population

The target populations consisted of 17 public secondary schools in Uriri District where reproductive health education is being implemented and all the school administrators/managers that were 17 principals and 17 deputy principals hence 34 school managers/administrators, 116 teachers would be targeted thus a total of 150 targeted populations.

3.4. Sample Size and Sampling Procedure

3.4.1. Sample Size

The sample consisted of the 17 secondary schools; the school managers were purposively sampled since they hold critical information to this study and according to (Mugenda and Mugenda, 2003), populations which were less than 36 should always be taken as sample. For the teachers from the secondary schools a sample of 70 percent was taken which brought to 85 chosen from the target population of 120 (Ary, 1972). Thus a total sample size of 108 respondents was picked for the study that is 23+85=108. The sample was calculated using the formula by Fisher et al. (1983) for determining the sample size when the population is less than 10,000. The confidence interval will be 95% and a margin error of 5% where

nf- desired sample size. (When the target population is less than 10,000)

n-desired sample size. (When the target population is more than 10,000)

N-the estimate of the population size

$$n = \frac{Z^2 pq}{d^2}$$

Where:

n-the desired sample size

z-the standard normal deviate at the required 95% confidence level (z=1.96 CI)

p- The proportion in the target population estimated to have characteristics being measured.

q=1-p

d-the level of statistical significance set

Therefore will be:

$$\mathbf{N} = \frac{(1.96)^2 (0.5)(0.5)}{(0.05)^2}$$

$$= \frac{3.8416(0.5)(0.5)}{0.0025}$$

= 400 respondents

The desired sample size 'N' is 105 respondents. The sample size is worked out below:-

$$\mathbf{Nf} = \frac{400}{(1+400)/108}$$

=108 (A sample size of 108 was used for this study)

3.4.2. Sampling Procedure

Table 3.1. Sampling procedure

Wards	West Kanyamkago	North Kanyamkago	Central kanyamkago	South Kanyamkago	East kanyamkago	Total
Targeted Schools	**3**	**3**	**2**	**6**	**2**	**17**
Targeted School Managers	**5**	**8**	**4**	**8**	**5**	**30**
Targeted Teachers	**10**	**31**	**10**	**55**	**14**	**120**
Sample School Managers	**4**	**6**	**3**	**6**	**4**	**23**
Sample Teachers	**7**	**22**	**7**	**39**	**10**	**85**

Source: Field Data

The study employed stratified random sampling technique to select the sample. The stratified sampling involved dividing the population into homogenous sub-groups and then taking a simple random sample in each sub group. To increase efficiency, it was also important to treat homogenous parts of the population as populations in their own rights. Each homogenous part of the population is referred to as a stratum and simple random samples were taken from each stratum independently of each other (Mugenda and Mugenda, 2003). In this study the schools were clustered and the population stratified into wards. The schools were then randomly selected to provide proportional random representation. Seventeen secondary schools were used as study sample. These institutions, their managers/administrators, the teachers, were used as respondents for the study because they constituted the most readily accessible source of information about the implementation of reproductive health education in those schools.

The choice of stratified/proportional random sampling was to ensure proper representation of each of the homogenous subgroups in the sample. 70% of the targeted teachers and school managers/administrators were sampled then complete census was applied to have eighty five teachers' respondents and twenty three school managers/administrators thus a total of 108 respondents.

3.5. Research Instruments

The study used questionnaires for data collection. Studies by (Bowling, 1999) revealed that the use of questionnaire for survey research was the best instrument for collecting data because as surveys are normally carried out in natural settings, questionnaire increases the external validity of the study. The questionnaires were administered to school managers/administrators and school teachers. The questions were developed based on information and experiences derived from review of literature on reproductive health/sexuality education implementation strategies. The selection of the tool was also guided by the nature of the data to be collected, availability as well as the objective of the study. The questionnaire was used since the study was concerned mainly with variables which could not be observed directly such as views, opinions and the population was literate they were not having the difficulty in responding to the question items. The questionnaire had section A which contained fourteen set of questions which was answered by school administrators/managers and teachers and section B which carried three question items and was answered by sampled teachers. In total there were seventeen sets of questions.

3.5.1. Piloting of the Instruments

Piloting is a mini or preliminary study undertaken to establish the effectiveness of a study research instrument (Mugenda and Mugenda, 2003). Pretest a sample should be between 1% and 10% of the study sample size (mugenda and mugenda, 2003) in this study a pretest was done to 11 that is 10% of sample size of 108.

3.5.2. Validity of the Instruments

In order to ensure the validity of the instruments, self-structured sets of questionnaires was referred to curriculum experts, reproductive health education experts and psychologists from the University of Nairobi for vetting so as to ensure its appropriateness, relevance and clarity,

adequate coverage of the research objectives and peer review.This helped in content validity process of the instruments.

3.5.3. Reliability of the Instruments

After the revision and validation of the research instruments test-retest measure of reliability was applied to the two set of questionnaires to the population that was not sampled.Here the research instrument was administered to the same respondents two times. After the first administration, sometime was allowed to elapse in this case two week elapsed, long enough to eliminate respondents by remembering the responses given in the first round. The score on the two sets of measures were then correlated to obtain an estimated coefficient of reliability. The coefficient was computed using the Spearman rank order correlation, a positive correlation coefficient for the questionnaire of over (r) 0.75 was judged high enough to consider the instrument reliable (Orodho, 2009). For this study it was found to be 0.84 hence the instruments were reliable.

3.6. Data Collection Procedures

Copies of the questionnaires were personally administered to the respondents. Before the consent of the participants was sought, the participants were allowed to participate voluntarily and they had the right to withdraw partially or completely from the process. Confidentiality of the data provided by individuals or/ identifiable participants and their anonymity was maintained. The participants/correspondents were allowed to react to the way in which the researcher wishes to collect data. Privacy of the respondents were upheld as none of the participants was harassed, or induced to participate, they were not contacted at unreasonable time and place, the participants determined when to participate in the data collection process and the participants were guided to answer the questions.

3.7. Data Analysis Techniques

The completed sets of questionnaires were collected and analyzed using cross tabulation correlation since the data were in nominal form. We would classify the variables into two or more categories and then cross classify the variable in these sub-categories. Then we sought of the relationship between them (Kothari, 2003).

Table: 3.2. Operationalization Table

Objective	Type of variable	Indicator	Level of Scale	Data Collection method	Analysis technique
To establish the extent to which school curriculum influence implementation of reproductive health education in public secondary schools in Uriri District of Migori County	Independent	Testing, Time-tabled, Examinable and Non-Examinable subjects	Nominal	questionnaire	Quantitative and Qualitative
To determine the extent to which school management influence implementation of reproductive health education in public secondary schools in Uriri District of Migori county	Independent	Support to teachers, Availability of learning-teaching materials, Biasness towards the examinable subjects and other supports towards the RHE	Nominal	Questionnaire	Quantitative and Qualitative
To investigate	Independent	Practicing,	Nominal	Questionnaire	Quantitative

how teachers influence implementation of reproductive health education in public secondary schools in Uriri District of Migori County		teaching, methodology, reason for teaching RHE			
To establish the extent to which resource materials influence implementation of reproductive health education in public secondary schools in Uriri District of Migori County	Independent	Source, availability, Type and Usage	Nominal	Questionnaire	Quantitative
To determine how the school sponsors influence implementation of reproductive health education in public secondary schools in Uriri District of Migori County	Independent	Support to teachers & students	Nominal	Questionnaire	Quantitative

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION

4.1. Introduction

This chapter presents the analysis of data, presentation as well as their interpretation and discussions. The data from the questionnaire was presented using the frequency tables in section (A) which had the demographic characteristics and other sections are presented using the chi-square tables basing on the research hypothesis. Quantitative data was analyzed using SPSS version 19 both for windows, while qualitative data was presented by way of narration.

4.2. Response Rate

Response rate is the observed questionnaires received from the field by the respondents. The researcher administered 108 questionnaires; there was 97.2% questionnaire return rate that is three questionnaires were not returned, hence the 105 were analyzed. According to (Mugenda and Mugenda, 2003) for returned rate of 75% and above for descriptive statistics is satisfactory for analysis. Thus, this study which is descriptive in nature, the return rate of 97.2% is very satisfactory

4.3. Demographic characteristics of the respondents.

The researcher collected demographic information from the respondents. This was achieved by assessing respondents' gender, age bracket, marital status, and level of education, employer and finally the profession.

4.3.1. Distribution of respondents by gender

Table 4.1: Distribution of respondents by gender

	Frequency	Valid Percent
Male	74	74.1
Female	27	25.9
Total	**105**	**100.0**

74.1% were males and 25.9% were female respondents of the sampled population.

4.3.2. Distribution of respondents by age bracket

Table 4.2: Distribution of respondents by age bracket

		Frequency	Valid Percent
Valid	**20-30**	31	29.5
	31-40	25	23.8
	41-50	26	24.8
	51 and above	23	21.9
	Total	**105**	**100.0**

Majority of the respondents were of 20-30 years old that is 29.5% followed by those of the age 41-50 that is 24.8%, then those of the age 31-40 years old that is 23.8% and finally those of the age 51 and above that is 21.9%.

4.3.3. Distribution by marital status

Table 4.3: Distribution of respondents by marital status

		Frequency	Valid Percent
Valid	**Single**	23	21.9
	Married	82	78.1
	Total	**105**	**100.0**

78.1% were of the respondents were married and 21.9% were single.

4.3.4. Distribution of respondents by Level of Education

Table 4.4: Distribution of respondents by Education

		Frequency	Valid Percent
Valid	**Degree**	105	100.0

All respondents were degree holders.

4. 3.5. Distribution of respondents by employer

Table 4.5: Distribution of respondents by employer

		Frequency	Valid Percent
Valid	**Tsc**	86	81.5
	Bog	19	18.5
	Total	**105**	**100.0**

81.5% of the respondents were employed by TSC while 18.5% were employed by the board of governors.

4.3.6. Distribution of by profession

Table 4.6: Distribution of respondents by profession

		Frequency	Valid Percent
Valid	**Teacher**	104	90.5
	Others	1	9.5
	Total	**105**	**100.0**

90.5% of the respondents are teachers by profession while 9.5% are not trained teachers.

4.4. Factors influencing implementation of reproductive health education in public secondary schools

This section presents findings from data collected on the main theme of the study (reproductive health education and the factors influencing its implementation.

4.4.1. Influence of school curriculum

Table 4.7. Teaching of reproductive health education as a special session

	Observed N	Expected N	Residual
Yes	74	35.0	39.0
No	31	70.0	-39.0
Total	**105**		

Table 4.8. Test Statistics

Special Session	
Chi-Square(a)	16.67
df	1
Asym Sig.	.000

0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 35.0.

4.4.1.1. Interpretation of output from chi-square

In the first table the observed frequencies from the data are presented, showing that 74 out of the 105 (70.5%) are taught through special session. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 74 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between special session and implementation of reproductive health education in the current sample of (70.5%) as compared with the value of (33.3%) that was hypothesized, chi-square (1,

n=105)=16.7, p>0.00. This means that special sessions had influence of reproductive health education in schools.

Table. 4.9. Reproductive health Education taught by regular teachers (Timetabled)

	Observed N	Expected N	Residual
Yes	27	35.0	-8.0
No	78	70.0	8.0
Total	**105**		

Table. 4.10. Test Statistics

	Regular Teachers (Time Tabled)
Chi-Square(a)	.667
df	1
Asymp. Sig.	.414

A 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 35.0.

4.4.1.2. Interpretation of output from the chi-square

In the first table the observed frequencies from the data are presented, showing that 27 out of the 105 (25.7%) are taught through regular teachers. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 27 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between regular teachers (timetabled) and implementation of reproductive health education in the current sample of (25.7%) as compared with the value of (33.3%) that was hypothesized, chi-square (1, n=105)=0.7, p<0.414

Table .4.11. Reproductive health Education taught as integrated/infused in other areas of the curriculum

	Observed N	Expected N	Residual
Yes	58	35.0	23.0
No	47	70.0	-23.0
Total	**105**		

Table 4.12. Test Statistics

Integrated/Infused	
Chi-Square(a)	6.000
df	1
Asymp Sig.	.014

A 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 35.0.

4.4.1.3. . Interpretation of output from the chi-square

In the first table the observed frequencies from the data are presented, showing that 58 out of the 105 (55.23%) are through integration or infused in other examinable subjects. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 58 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between integration or infusion of reproductive in other examinable subjects and implementation of reproductive health education in the current sample of (55.23%) as compared with the value of (33.3%) that was hypothesized, chi-square (1, n=105)=6.0, p>0.014. This means that examinable subject influences the implementation of reproductive health education

Table 4.13. Physical Education taught as Non-Examinable subject

	Observed N	Expected N	Residual
Yes	102	35.0	67.0
No	3	70.0	-67.0
Total	**105**		

Table 4.14. Test Statistics

Physical Education	
Chi-Square(a)	37.500
df	1
Asymp.Sig.	.000

A 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 35.0.

4.4.1.4. Interpretation of output from the chi-square

In the first table the observed frequencies from the data are presented, showing that 102 out of the 105 (97.14%) that physical education is taught as non-examinable subjects. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 102 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between implementing physical education as non-examinable subjects and implementation of reproductive health education in the current sample of (97.14%) as compared with the value of (33.3%) that was hypothesized, chi-square (1, n=105)=6.0, p>0.000.

Table 4.15. HIV/AIDS Taught as Non-Examinable subject

	Observed N	Expected N	Residual
Yes	95	35.0	60.0
No	10	70.0	-60.0
Total	**105**		

Table 4.16. Test Statistics

HIV/AIDS	
Chi-Square(a)	10.667
df	1
Asymp. Sig.	.001

A 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 35.0.

4.4.1.5. Interpretation of output from the chi-square

In the first table the observed frequencies from the data are presented, showing that 95 out of the 105 (90.48%) that HIV/AIDS is taught as non-examinable subjects. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 95 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between teaching HIV/AIDS as non-examinable subjects and implementation of reproductive health education in the current sample of (90.48%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.0, p>0.001

Table 4.17.Pastoral Studies taught as Non-Examinable Subject

	Observed N	Expected N	Residual
Yes	51	35.0	16.0
No	54	70.0	-16.0
Total	**105**		

Table 4.18. Test Statistics

Pastoral Studies	
Chi-Square(a)	2.667
df	1
Asymp.Sig.	.102

A 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 35.0.

4.4.1.6. Interpretation of output from the chi-square

In the first table the observed frequencies from the data are presented, showing that 51 out of the 105 (48.15%) that pastoral studies is discussed as non-examinable subjects. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 51 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between discussing pastoral studies as non-examinable subjects and implementation of reproductive health education in the current sample of (48.15%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.0, p<0.102. This means that the teaching of pastoral studies has no relationship with implementation of reproductive health education.

Table 4.19. Influence of Examinable subjects on the implementation of Reproductive health Education

	Frequency	Valid Percent
Examinable subjects takes more time	74	74.1
Examinable subjects are integrated	27	25.9
Total	**105**	**100.0**

From the above frequency table, 74.1% of the respondents said that the examinable subjects are given more time in our secondary schools than the implementation of reproductive health education. 25.9% said that the reproductive health education is integrated within other examinable subjects.

4.4.2. Influence of resource materials

Table .4.20. Video/CDs as teaching-learning material of reproductive health education

	Observed N	Expected	Residual
Yes	62	35.0	27.0
No	43	70.0	-27.0
Total	**105**		

Table. 4.21. Test Statistics

Video/CDs	
Chi-Square(a)	8.167
df	1
Asymp.Sig.	.004

A 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 35.0.

4.4.2.1. Interpretation of output from the chi-square

In the first table the observed frequencies from the data are presented, showing that 62 out of the 105 (59.26%) that video/CDs are use to teach reproductive health education. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 62 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between using video/CDs as teaching-learning materials and implementation of reproductive health education in the current sample of (59.26%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.0, p>0.004. This means that the teaching of reproductive health education using video/CDs has relationship with its implementation.

Table. 4.22. Text books as teaching-learning materials of reproductive health education

	Observed N	Expected N	Residual
Yes	89	35.0	54.0
No	16	70.0	-54.0
Total	**105**		

Table. 4.23. Test statistics

Text Books	
Chi-Square(a)	32.667
df	1
Asymp. Sig.	.000

4.4.2.2. Interpretation output of chi-square

In the first table the observed frequencies from the data are presented, showing that 89 out of the 105 (85.19%) that text books are use to teach reproductive health education. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 89 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between using text books as teaching-learning materials and implementation of reproductive health education in the current sample of (85.19%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.0, p>0.000. This means that text books are widely used in teaching the reproductive health education have grand effect in its implementation.

Table. 4.24. Pamphlets as teaching-learning materials of reproductive health education

	Observed N	Expected N	Residual
Yes	47	35.0	12.0
No	58	70.0	-12.0
Total	**105**		

Table .4.25. Test Statistics

Pamphlets	
Chi-Square(a)	1.500
df	1
Asymp. Sig.	.221

4.4.2.3. Interpretation output of the chi-square

In the first table the observed frequencies from the data are presented, showing that 47 out of the 105 (44.44%) that pamphlets are used to teach reproductive health education. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 47 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between using pamphlets as teaching-learning materials and implementation of reproductive health education in the current sample of (44.44%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.0, $p<0.221$. This means that pamphlets are not widely used in teaching the reproductive health education in schools.

Table 4.26. Handouts from organizations as teaching-learning materials of reproductive health education

	Observed N	Expected N	Residual
Yes	78	35.0	43.0
No	27	70.0	-43.0
Total	**105**		

Table 4.27. Test Statistics

Handouts From Organizations	
Chi-Square(a)	20.167
df	1
Asymp. Sig.	.000

4.4.2.4. Interpretation of output of chi-square

In the first table the observed frequencies from the data are presented, showing that 78 out of the 105 (74.1%) that handouts from organizations are used to teach reproductive health education. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 78 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between using handouts from organizations as teaching-learning materials and implementation of reproductive health education in the current sample of (74.1%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=20.17., p>0.00. This means that handouts from organizations are widely used in teaching the reproductive health education in school.

Table. 4.28. Kenya Institute of Education as source of teaching-learning materials of reproductive health education

	Observed N	Expected N	Residual
Yes	47	35.0	12.0
No	58	70.0	-12.0
Total	**105**		

Table. 4.29. Test Statistics

K.I.E	
Chi-Square(a)	1.500
df	1
Asymp. Sig.	.221

4.4.2.5. Interpretation of output of chi-square

In the first table the observed frequencies from the data are presented, showing that 47 out of the 105 (44.4%) that materials from K.I.E are used to teach reproductive health education. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 47 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between using K.I.E materials from organizations as teaching-learning materials and implementation of reproductive health education in the current sample of (44.4%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=1.5, p<0.221 This means that K.I.E. materials are widely not used in teaching the reproductive health education in schools.

Table. 4.30. Ministry of education as source of teaching –learning material of reproductive health education.

	Observed N	Expected N	Residual
Yes	66	35.0	31.0
No	39	70.0	-31.0
Total	**105**		

Table. 4.31. Test Statistics

Ministry Of Education	
Chi-Square(a)	10.667
df	1
Asymp. Sig.	.001

4.4.2.6. Interpretation of output of chi-square

In the first table the observed frequencies from the data are presented, showing that 66 out of the 105 (63%) that materials from ministry of education are used to teach reproductive health education. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 66 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between using materials from ministry of education as teaching-learning materials and implementation of reproductive health education in the current sample of (63%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=10.67, p>0.001. This means that from materials from ministry of education are widely used in teaching the reproductive health education in schools.

Table.4.32. Non Governmental Organizations as a source of teaching-learning material of reproductive health education

	Observed N	Expected N	Residual
Yes	89	35.0	14.0
No	16	70.0	-14.0
Total	**105**		

Table. 4.33. Test Statistics

NGOs	
Chi-Square(a)	32.667
df	1
Asymp. Sig.	.000

4.4.2.7. Interpretation of output of chi-square

In the first table the observed frequencies from the data are presented, showing that 89 out of the 105 (84.76%) that materials from Non-governmental organizations are used to teach reproductive health education. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 89 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between using materials from Non-governmental organizations as teaching-learning materials and implementation of reproductive health education in the current sample of (84.76%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=32.67, p>0.000. This means that from materials from Non-governmental organizations are widely used in teaching the reproductive health education in schools.

Table. 4.34. Teaching-Learning materials used for teaching reproductive health education influences its implementation

	Frequency	Valid Percent
Learning-teaching materials not enough	84	80.0
Learning-Teaching materials only gives a hint	21	20.0
Total	**105**	**100.0**

80% of the respondents agreed that the teaching-learning materials are not enough hence they are inadequate and 20% of the respondents said that the teaching-learning materials only gives a hint of reproductive health education.

4.4.3. Influence of teachers

Table 4.35.English as main teaching subject of teachers implementing reproductive health education in public secondary schools

	Observed N	Expected N	Residual
Yes	43	35.0	8.0
No	62	70.0	-8.0
Total	105		

Table. 4. 36. Test Statistics

Main Teaching Subject-English	
Chi-Square(a)	.667
df	1
Asymp. Sig.	.414

4.4.3.1. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 43 out of the 105 (40.7%) that English is the main teaching subject of the teachers teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 43 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between English as the main teaching subject of the teacher implementing the reproductive health education in the current sample of (40.7%) as compared with the value of (33.3%) that

was expected, chi-square (1, n=105)=0.667, p<0.414. This means that teachers having English as their main teaching subject are not teaching the reproductive health education in schools.

Table. 4.37. Kiswahili as main teaching subject of teachers implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	27	35.0	-8.0
No	78	70.0	8.0
Total	**105**		

Table. 4.38. Test Statistics

Main Teaching Subject-Kiswahili	
Chi-Square(a)	.667
df	1
Asymp. Sig.	.414

4.4.3.2. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 27 out of the 105 (25.9%) that Kiswahili is the main teaching subject of the teachers teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 27 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between Kiswahili as the main teaching subject of the teacher implementing the reproductive health education in the current sample of (25.9%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=0.667, p<0.414. This means that teachers having Kiswahili as their main teaching subject are not teaching the reproductive health education in schools.

Table. 4.39. Mathematics as the main teaching subject of the teacher teaching reproductive health education in public secondary school.

	Observed N	Expected N	Residual
Yes	31	35.0	-1.0
No	74	70.0	1.0
Total	**105**		

Table 4.40. Test Statistics

Main Teaching Subject-Maths	
Chi-Square(a)	.167
df	1
Asymp. Sig.	.683

4.4.3.3. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 31 out of the 105 (29.6%) that mathematics is the main teaching subject of the teachers teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 31 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between mathematics as the main teaching subject of the teacher implementing the reproductive health education in the current sample of (29.6%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=0.167, p<0.683. This means that teachers having mathematics as their main teaching subject are not teaching the reproductive health education in schools.

Table.4.41. Sciences as the main teaching subject of the teachers implementing reproductive health education.

	Observed N	Expected N	Residual
Yes	86	35.0	51.0
No	19	70.0	-51.0
Total	**105**		

Table. 4.42. Test Statistics

Main Teaching Subject-Sciences	
Chi-Square(a)	28.167
df	1
Asymp. Sig.	.000

4.4.3.4. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 86 out of the 105 (81.5%) that sciences is the main teaching subject of the teachers teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 86 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between sciences as the main teaching subject of the teacher implementing the reproductive health education in the current sample of (81.5%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=28.17, $p<0.000$. This means that teachers having sciences as their main teaching subject are teaching the reproductive health education in schools.

Table. 4.43. Humanities as main teaching subject of the teachers implementing reproductive health education in public secondary school.

	Observed N	Expected N	Residual
Yes	74	35.0	39.0
No	31	70.0	-39.0
Total	**105**		

Table. 4.44. Test Statistics

Main Teaching Subject-Humanities	
Chi-Square(a)	16.667
df	1
Asymp. Sig.	.000

4.4.3. 5. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 74 out of the 105 (70.4%) that humanities is the main teaching subject of the teachers teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 74 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between humanities as the main teaching subject of the teacher implementing the reproductive health education in the current sample of (70.4%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=16.67, p<0.000. This means that teachers having humanities as their main teaching subject are teaching the reproductive health education in schools.

Table. 4.45. Applied subjects as the main teaching subject of the teachers implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	47	35.0	12.0
No	58	70.0	-12.0
Total	**105**		

Table 4.46. Test Statistics.

Main Teaching Subject-Applied Subjects	
Chi-Square(a)	1.500
df	1
Asymp.Sig.	.221

4.4.3.6. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 47 out of the 105 (44.4%) that applied subjects is the main teaching subject of the teachers teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 47 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was not significant relationship between applied subjects as the main teaching subject of the teacher implementing the reproductive health education in the current sample of (44.4%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=1.5, $p<0.221$. This means that teachers having applied subjects as their main teaching subject are not teaching the reproductive health education in schools.

Table 4. 47. Guidance and counseling as additional responsibility of those teachers implementing reproductive health education in public secondary schools.

Observed N	
Yes	105
Total	**105 (a)**

A 1 cell was generated, but 2 expected frequencies were specified. Chi-Square Test cannot be performed.

4.4. 3.7. Interpretation of the chi-square output

All respondents agreed that guidance and counseling masers teach reproductive health in one way or the other

Table. 4.48. Career masters as additional responsibility of teachers implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	58	35.0	23.0
No	47	70.0	23.0
Total	**105**		

Table .4.49. Test Statistics

Career Master	
Chi-Square(a)	6.000
df	1
Asymp. Sig.	.014

4.4.3.8 Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 58 out of the 105 (55.6%) that teachers in charge of careers in schools are teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 58 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between career master as additional responsibility of the teachers implementing the reproductive health education in the current sample of (55.6%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.000, p>0.014. This means that teachers having career master as additional responsibility are teaching the reproductive health education in schools.

Table .4.50. Head of languages as additional responsibility of teachers implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	35	35.0	.0
No	70	70.0	.0
Total	**105**		

Table. 4.51. Test Statistics

HOD Languages	
Chi-Square(a)	.000
df	1
Asymp.Sig.	1.000

4.4.3.9. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 35 out of the 105 (33.3%) that teachers who are head of languages in schools are teaching reproductive health

education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 35 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between head of languages as additional responsibility of the teachers implementing the reproductive health education in the current sample of (33.3%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=0.000, p<1.000. This means that teachers having head of languages as additional responsibility are teaching the reproductive health education in schools.

Table. 4.52. Head of Health/Health clubs & Societies as additional responsibility of teachers implementing reproductive health education.

	Observed N	Expected N	Residual
Yes	58	35.0	23.0
No	47	70.0	-23.0
Total	**105**		

Table. 4.53. Test Statistics

HOD Health & Societies	
Chi-Square	6.000[a]
df	1
Asymp. Sig.	.014

4.4.3.10. Interpretation of chi-square output

In the first table the observed frequencies from the data are presented, showing that 58 out of the 105 (55.6%) that head of health/health clubs & societies in schools are teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 58 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between head of health/health clubs & societies as additional responsibility of the teachers implementing the reproductive health education in the current sample of (55.6%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.000, p>0.014. This means that teachers having head of health/health clubs & societies as additional responsibility are teaching the reproductive health education in schools.

Table. 4.54. Head of Humanities as additional responsibility of teachers implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	35	35.0	.0
No	70	70.0	.0
Total	**105**		

Table. 4.55. Test Statistics.

HOD Humanities	
Chi-Square	.000[a]
df	1
Asymp. Sig.	1.000

4.4.3.11. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 35 out of the 105 (33.3%) that teachers who are head of humanities in schools are teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 35 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between head of humanities as additional responsibility of the teachers implementing the reproductive health education in the current sample of (33.3%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=0.000, p<1.000. This means that teachers having head of humanities as additional responsibility are not teaching the reproductive health education in schools.

Table 4.56. Head of sciences as additional responsibility of teachers implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	47	35	12.0
No	58	70.0	-12.0
Total	**105**		

Table. 4.57. Test Statistics

HOD Sciences	
Chi-Square	1.500[a]
df	1
Asymp. Sig.	.221

4.4.3.12. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 47 out of the 105 (44.4%) that head of sciences in schools are teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 47 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between head of sciences as additional responsibility of the teachers implementing the reproductive health education in the current sample of (44.4%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=1.500 p<0.221. This means that teachers having head of sciences as additional responsibility are not teaching the reproductive health education in schools.

Table 4.58. Head of mathematics as additional responsibility of teachers implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	12	35.0	-23.0
No	93	70.0	23.0
Total	**105**		

Table. 4.59. Test Statistics

HOD Mathematics	
Chi-Square	6.000[a]
df	1
Asymp. Sig.	.014

4.4.3.13. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 12 out of the 105 (11.1%) that head of mathematics in schools are teaching reproductive health education in schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 12 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between head of mathematics as additional responsibility of the teachers implementing the reproductive health education in the current sample of(11.1%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.000, p>0.014. This means that teachers having head of mathematics as additional responsibility are teaching the reproductive health education in schools.

Table 4.60.Initial background training as the reason as to why the teacher is implementing the reproductive health in public secondary schools

	Observed N	Expected N	Residual
Yes	70	35.0	35.0
No	35	70.0	-35.0
Total	**105**		

Table 4.61. Test statistics.

Initial Background Training	
Chi-Square	13.500[a]
df	1
Asymp. Sig.	.000

4.4.3.15. Interpretation of chi-square output

In the first table the observed frequencies from the data are presented, showing that 70 out of the 105 (66.7%) that because of initial background training teachers are assigned responsibility of implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 70 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between initial background training of the teachers implementing the reproductive health education in the current sample of(66.7%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=13.500, p>0.000. This means that teachers having initial background trainings are teaching the reproductive health education in schools.

Table 4.62. Being in-charge of guidance and counseling as the reason as to why the teacher is implementing the reproductive health in public secondary schools.

Observed N	
Yes	105
Total	**105[a]**

4.4.3.14. Interpretation of chi-square output

All the respondents that is 105 out of 105 (100%) indicated that those teachers in charge of guidance and counseling do implement reproductive health education in their schools.

Table. 4.63. In-service training as the reason as to why the teacher is implementing the reproductive health in public secondary schools.

	Observed N	Expected N	Residual
Yes	51	35.0	16.0
No	54	70.0	-16.0
Total	**105**		

Table. 4.64. Test Statistics.

In-Service Training	
Chi-Square	2.667[a]
df	1
Asymp. Sig.	.102

4.4.3.15. Interpretation of chi-square output

In the first table the observed frequencies from the data are presented, showing that 51 out of the 105 (48.1%) that because of in-service training teachers are assigned responsibility of implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 51 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between in-service training of the teachers implementing the reproductive health education in the current sample of(48.1%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=2.667, p<0.102. This means that teachers having in-service trainings are not teaching the reproductive health education in schools.

Table. 4.65. Punishment as the reason as to why the teacher is implementing the reproductive health in public secondary schools.

	Observed N	Expected N	Residual
Yes	4	35.0	-31.0
No	101	70.0	31.0
Total	**105**		

Table. 4. 66. Test Statistics

Punishment From School Administration	
Chi-Square	10.667[a]
df	1
Asymp. Sig.	.001

4.4.3.16. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 4 out of the 105 (3.7%) that because of punishment teachers are assigned responsibility of implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 4 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between punishment of the teachers implementing the reproductive health education in the current sample of(3.7%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=10.667, p>0.001. This means that teachers are not implementing the reproductive health education in schools because of punishment.

Table. 4.67. How main teaching subjects of the teachers and additional responsibility of the teachers influences implementation of reproductive health education in public secondary schools

	Frequency	**Valid Percent**
Main teaching subjects & additional responsibility takes most of time for teachers	105	100.0
Total	**105**	**100.0**

All respondents agreed that the main teaching subject, the additional responsibility takes most their time hence not implementing the reproductive health education in public secondary schools.

4.4. Influence of School Sponsor

Table. 4.68. Church or organization sponsoring the school implementing reproductive health education

	Frequency	Percentages
Roman Catholic	54	51.4
Angelican Church Of Kenya	12	11.4
Salvation Army	19	18.1
Other Churches	8	7.6
Other Organizations	12	11.4
Total	**105**	**100**

4.4.3.17. Interpretation of the output

From the above table 54 (51.4%) of the schools are sponsored by the roman catholic, 12 (11.4%) of the schools are sponsored by the Angelica Church of Kenya, 19 (18.1%) of the schools are sponsored by salvation army, 8 (7.6%) of the schools are sponsored by other churches e.g Church of God assemblies, The church of Christ around the world among others, 12 (11.4%) of the schools are sponsored by other organizations e.g. the District Education Board (DEB).

Table .4.69. Provision of teaching & learning materials as the support church/organization sponsor give their schools in implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	58	35.0	23.0
No	47	70.0	-23.0
Total	105		

Table. 4.70. Test Statistics

Teaching-Learning Materials	
Chi-Square	6.000[a]
df	1
Asymp. Sig.	.014

4.4.4.2. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 58 out of the 105 (55.6%) that school sponsors provide teaching & learning materials in implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 58 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between provision of teaching & learning materials by school sponsors and implementing the reproductive health education in the current sample of(55.6%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.000, p>0.014. This means that school sponsors provide teaching & learning materials for implementing the reproductive health education in schools.

Table. 4.71. Provision of resource persons as the support church/organization sponsor give their schools in implementing reproductive health education in public secondary schools.

	Observed N	Expected N	Residual
Yes	89	35.0	54.0
No	16	70.0	-54.0
Total	**105**		

Table. 4.72. Test Statistics.

Resource Persons	
Chi-Square	32.667[a]
df	1
Asymp. Sig.	.000

4.4.4.3. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 89 out of the 105 (85.2%) that school sponsors provide resource persons in implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 89 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between provision of resource persons by school sponsors and implementing the reproductive health education in the current sample of(85.2%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=32.667, p>0.000. This means that school sponsors provide resource persons for implementing the reproductive health education in schools.

Table. 4.73. Taking students for excursions as the support church/organization sponsor give their schools in implementing reproductive health education in public secondary schools.

	Observed N	**Expected N**	**Residual**
Yes	12	35.0	-23.0
No	93	70.0	23.0
Total	**105**		

Table. 4.74. Test statistics.

Taking Students For Excursion	
Chi-Square	6.000[a]
df	1
Asymp.Sig.	.014

4.4.4.4. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 12 out of the 105 (11.1%) that school sponsors take students for excursions in implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 12 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between taking students for excursion by school sponsors and implementing the reproductive health education in the current sample of(11.1%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=6.000, p>0.014. This means that school sponsors taking students for excursion do not relate with implementing the reproductive health education in schools.

Table.4.75. How the sponsor influences the implementation of reproductive health education in public secondary schools.

	Frequency	Valid Percent
Morality /Spirituality	93	88.6
Church doctrines	12	11.4
Total	**105**	**100.0**

88.6% of the respondents stated that the sponsor mainly discuss the morality and spirituality and this shows that they main the status quo of abstaining from sexual issue until marriage while

11.4% of the respondents said that most of the sponsors which are church base mainly talk of the church doctrines this shows that there is nothing that touches on the sexuality education.

4.4.5. Influence of school Administrators/School managers

Table.4.76. Priority to examinable subjects by school administrators

	Frequency	Percentages
Strongly Agree	43	41
Agree	31	29.5
Strongly Disagree	12	11.4
Disagree	16	15.2
No Response	3	2.9
Total	**105**	**100.0**

4.4.5.1. Interpretation of the output

The data shows that 43 (41%) strongly agree that school administrators give more priority to examinable subjects, 31 (29.5%) agree that school administrators give more priority to examinable subjects, 12 (11.4%) strongly disagree that school administrators give priority to examinable subjects, 16 (15.2%) disagree that school managers give priority to examinable subjects and finally 3 (2.9%) had no response. This shows that generally school administrators give priority to examinable subjects.

Table. 4.77. **Purchase of teaching-learning materials as the support school managers give in implementing reproductive health education in their schools.**

	Observed N	Expected N	Residual
Yes	74	35.0	39.0
No	31	70.0	-39.0
Total	**105**		

Table. 4.78. Test Statistics

Purchase Of Teaching-Learning Materials	
Chi-Square	16.667[a]
df	1
Asymp. Sig.	.000

4.4.5.2. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 74 out of the 105 (70.3%) that school managers provide support of purchasing teaching-learning materials in implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 74 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between purchase of teaching-learning materials by school managers/administrators and implementing the reproductive health education in the current sample of(70.3%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=16.667, p>0.000. This means that school managers/administrators purchasing teaching- learning materials influences implementation of the reproductive health education in schools.

Table 4.79. Provision of funds for outings and innings as the support school managers give in implementing reproductive health education in their schools.

	Observed N	Expected N	Residual
Yes	47	35.0	12.0
No	58	70.0	-12.0
Total	**105**		

Table 4.80. Test Statistics

Funds For Outings and Innings	
Chi-Square	1.500[a]
df	1
Asymp. Sig.	.221

4.4.5.3. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 47 out of the 105 (44.4%) that school managers provide funds for outings and innings in implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 47 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between of funds for outing and innings provided by school managers/administrators and implementation the reproductive health education in the current sample of(44.4%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=1.500, p<0.221. This means that school managers/administrator provision of funds for outing and innings do not influences implementation of the reproductive health education in schools.

Table. 4.81. Provision of other resource persons as the support school managers give in implementing reproductive health education in their schools.

	Observed N	Expected N	Residual
Yes	62	35.0	27.0
No	43	70.0	-27.0
Total	**105**		

Table. 4.82. Test Statistics

Resource Persons	
Chi-Square	8.167[a]
df	1
Asymp. Sig.	.004

4.4.5.4. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 62 out of the 105 (59.3%) that school manager providing of other resources in implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 62 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was significant relationship between of other resource persons provided by school managers/administrators and implementation the reproductive health education in the current sample of(59.3%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=1.500, p>0.004. This means that school managers/administrator provision of other resource persons influences implementation of the reproductive health education in schools.

Table. 4.83. **Provision of trainings to teachers and students as the support school managers give in implementing reproductive health education in their schools.**

	Observed N	Expected N	Residual
Yes	47	35.0	12.0
No	58	70.0	-12.0
Total	**105**		

Table .4.84. Test Statistics

Training To Teachers & Students	
Chi-Square	1.500[a]
df	1
Asymp. Sig.	.221

4.4.5.5. Interpretation of the chi-square output

In the first table the observed frequencies from the data are presented, showing that 47 out of the 105 (44.4%) that school managers provide trainings to teachers and students in implementing reproductive health/sexuality education in their schools. The expected N from the specified (33.3%) is given. In this case, 35 cases were expected, while 47 cases were observed.

The test statistics table reports the results of the chi-square test which compares the expected and observed values. In this case, the chi-square test indicates there was no significant relationship between trainings to teachers and students provided by school managers/administrators and implementation the reproductive health education in the current sample of(44.4%) as compared with the value of (33.3%) that was expected, chi-square (1, n=105)=1.500, p<0.221. This means that school managers/administrators trainings to teachers and students do not influences implementation of the reproductive health education in schools.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter presents a summary of findings, conclusions and recommendations on the factors influencing implementation of reproductive health education in public secondary schools in Uriri district. First the study had to establish the demography of the school managers/administrators that is the head teachers & deputy head teachers, secondly the research had hypotheses which sought to test the relationship between school curriculum and implementation of reproductive health education, relationship between school management and implementation of the reproductive health education, relationship between teachers and implementation of reproductive health education, relationship between the resource materials and implementation of reproductive health education and the relationship between school sponsors and implementation of reproductive health education in public secondary schools. In fact five research hypotheses were formulated for the study.

5.2. Summary of the Findings

The researcher aim to establish the extent to which school curriculum influence implementation of reproductive health education in public secondary schools therefore the respondents were asked how reproductive health education is taught in their schools, findings of the study realized that there is significant relationship between the special sessions and integration/infusion of the reproductive health education in other areas of the curriculum as way of teaching the reproductive health education and its implementations in schools. The findings also realized that there was no relationship between the teaching of reproductive health education by regular teachers/timetabled and implementation of the reproductive health education. Finally the study realized that examinable subjects takes more time than the implementation of the non examinable subjects which reproductive health education is part of hence it influences the implementation of the reproductive health education in our public secondary schools.

On the extent to which teaching-learning materials influences the implementation reproductive health education, the videos/CDs, textbooks and handouts from NGOs had significant relationship with the implementation of the reproductive health education, this means that their use influences implementation of the reproductive education but pamphlets had no significant relationships which means that they are not being in the implementation of the RHE. On the

other hand most of these materials were from Ministry of education and non-governmental Organizations since they had significant relationship with the implementation of the RHE while material from K.I.E had no significant relationship that is most of the materials being used for implementation of RHE were not from K.I.E. last but not least there was general outcry that most of the materials used for implementation are not enough, therefore this influences the implantation of reproductive health education in our public secondary schools.

Teachers also influences the implementation of the reproductive health education in schools since there was significant relationship for those teachers teaching sciences and humanities especially for those teaching the biology as a subject and CRE as a subject respectively. This shows that, reproductive health education is implemented by teachers teaching Biology and C.R.E. However, teachers handling the English, Kiswahili, Mathematics and applied subjects do not normally implement the reproductive health education. It was also found out that additional responsibilities to teachers influences the implementation of the reproductive health education since all the respondents agreed that those teachers with the responsibility guidance and counseling each reproductive health education in schools, and this influences its implementation. Secondly, for those teachers who are career master and head of health & societies also had significance influence in the implementation, this is because there is personal contact of these teachers with the students. Thirdly, for those teachers who are in charge of languages, humanities, sciences and mathematics had no significant relationship with the implementation of the reproductive health education since reproductive health is not in their line of operation. Because of the initial background training of teacher, he or she is assigned the responsibility of implementing the reproductive health education in the school. In-service trainings and punishment are some of the least reasons why the responsibility of implementing the reproductive health education is assigned to the teachers since in-service trainings are hard to come by hence they had no significant relationship with implementation of the reproductive health education. This finding contradicts the results of studies by (Varga and Shongwe, 1999) that teachers are often assigned the duty of implementing reproductive health education as a punishment. The respondent, finally opines that the additional responsibility of the teachers takes mores of their time thus, do not implement the reproductive health education in the schools.

The school managers/administrators are biased towards the examinable subjects than the implementation of the reproductive health education; this was indicated by the teachers. It was also significant that school managers purchase teaching—learning materials for the implementation of the reproductive health education, however, the material are not effectively used for the implementation of the reproductive health education. The school managers also provide funds for outings and innings but this was not directly related to implementation of the reproductive health education, though students and teachers would go for the outings and organize innings with the authority of the school manager, the implementation of the reproductive health becomes informal among the students. Provision of the resource persons had significant relationship with implementation of the reproductive health education since most of the resource persons who offer the reproductive health education during special sessions in the school normally perform their activities in the school with the power and authority of the school manager/administrators hence the provision of resource persons influences the implementation of the reproductive education in the school. School managers/administrators do not provide trainings to students and teachers as part of support to implementation of the reproductive health education, this is also confirm by the fact that teachers are not assigned the responsibility implementing the reproductive health education because of the in-service trainings they receive, meaning they do not receive the trainings that is why there is no significant relationship between provision of the trainings and implementation of the reproductive health education. These results are supported by findings of (Idehen and Oshodin, 2008) who found that school administration is biased about reproductive health instruction. They further indicated that, though school administrators show some interest in reproductive health education, they do not provide an ideal teaching and learning environment. This is also corroborated by findings of (Ejifugha, 1999) who said that reproductive health education would lack meaning due to administrative constraints.

Most of the schools in Uriri District are sponsored by the Roman Catholic Church, some are also sponsored with other churches. Though the sponsors provide the teaching learning materials but they are not directly related with the implementation of the reproductive health education in the schools. The sponsors normally provide resource persons, that is the serving priest among others and it is at the prerogative of the resource persons to discuss the reproductive health issues during the sessions. The sponsors also do not normally take students for the excursion as

observed in the study. It was also found out that most of the school sponsors normally influences the morality/spirituality of the students and church norms/doctrines hence they have no influence in the implementation of the reproductive health education.

5.3. Conclusion

Based on the findings, the researcher concluded that there is significant relationship between the curriculum and implementation of the reproductive health education especially when offered as special session and integrated or infused within the curriculum thus curriculum influences implementation of reproductive health education. There is also significant relationship between the resource teaching-learning materials and implementation of the reproductive health education especially the commonly used materials such as video/CDs, textbooks and handouts from NGOs which are gotten from the Ministry of Education. The teaching subject of the teacher and the type of responsibility the teachers have in the school influences the implementation of the reproductive health education in the secondary schools. The school managers' actions influences the implementation of the reproductive health education in the schools and the sponsor mainly deals with the morality/spirituality and church doctrines hence have no influence on the implementation of the reproductive health education in most schools. These factors therefore influence the implementation of the reproductive education in the secondary schools except the school to some extent.

5.4. Recommendation

Based on the findings of the study, the researcher came up with the following recommendations:

1. The reproductive health education should be officially taught and examined by the government of Kenya

2. There should be official curriculum for the reproductive health education by the Kenya Institute of Curriculum Development to be used across the country.

3. The school teachers should be in-serviced on issues of the reproductive health education.

4. The peer to peer teaching should be encouraged among the students on matters touching their sexuality and this should be encouraged by the school managers/administrators.

5. For those who are trainings as teachers reproductive education should form part of their core courses so as to entrench the reproductive among the teachers during their formative years of trainings.

5.5. Suggestion for Further Research

Due to limitations of this study it was suggested that a study should be conducted to establish the factors behind the adolescents' pregnancy in the country. Secondly a study should be conducted to establish the low uptake of reproductive health services among the youths in Kenya.

REFERENCES

Aaro, l., Flisher, J., Kaaya, S., Onya, H., Fuglesang, M. Klepp, K. Schaalma, H. (2005):

Promoting sexual and reproductive health in early adolescence in South Africa and Tanzania: Development of atheory- and evidence-based intervention programme. Scandinavian Journal of Public Health, Preview article. Research Centre for Health promotion, University of Bergen, Norway.

Askew, ian, Chege J., Njue C., Radeny S., (2004: "A multi-sectoral approach to providing reproductive health information and services to young people in Western Kenya: The Kenya adolescent reproductive health project," FRONTIERS Final Report.Washington .D.C. Population Council.

Bandura A. (1997): Self-efficacy: The exercise of control. New York: Freeman,

Binagwaho A. (2009): Report on adolescents' health and HIV services in Rwanda, in the contextof their human rights, Kigali: Ministry of Health, Rwanda.

Bowling, A. (1999): Research Methods in Health; Investigating Health Services. Buckingham: University press.

Collins J. Goodman R. A. and Moulton A. D. (2008): School Health.Official Journal of the American School Health AssociationVol.78.No. 2. V.

Idehen C.O. and Oshodin O.G. (2008): Factors Affecting Health Instruction in Secondary Schools in Edo State, Nigeria, Faculty of Education, University of Benin, Benin City, Nigeria.

Kothari.C. R. 2003): Research Methodology Methods and Techniques. New Delhi: New Age International (P) Ltd., Publishers.

Lioyd B. C. (2004): Schooling and Adolescents Reproductive Behavior in Developing Countries.Washington D.C. Population Council- Millennium Project.

Mbananga, N. (2002): A critical analysis of reproductive health information in South Africa: Natal: Medical Research Council, South Africa.

Ministry of Health of Rwanda (2003): National Reproductive Health Policy. Kigali: Ministry of Health, Rwanda.

Mugenda, O.M., Mugenda A. G. (2003): Research Methods, Quantitative and qualitative Approaches. Nairobi: African Center for Technology Studies (ACTS) Press.

Mulama S. (2006): The Sexuality Education Needs of Teacher Trainees in Kenya, Post-Sexuality Leadership Development Fellowship Report Series No. 5.Lagos: Africa Regional Sexuality Resource Centre (ARSRC).

Mutai B. (2000): How to Write Quality Research Proposal, A complete and Simplified Recipe. Mysore: Good Touch Printers.

Neema S., Nakanyike M., Kibombo R. (2004): Adolescent sexual and Reproductive Health in Uganda; A synthesis of research Evidence.Occassional report No. 14, New York: The Alan Guttmacher Institute.

Ogunjimi, L.O. (2006): Attitude of Students and Parents towards the Teaching of sex educationin Secondary Schools in Cross Rivers State.Journal of Educational Research and Review Vol 1 (9), pp.347-349.

Smith G., Kippax S., Aggleton P., (2000): HIV and Sexual Health Education in Primary And secondary Schools. Findings from Selected Asia-pacific Countries.National Centre in HIV Social Research. Faculty of Arts and Social Sciences: The University of New South Wales.

Smith,A., Marisa, S., Mitchell, A., Walsh, J. Lyons, A. Blackman, P. Pitts. M. (2011): Sexuality education in Australian Secondary Schols.Results of the 1st National Survey of AustralianSecondary Teachers of Sexuality Education 2010. La Trobe University, the Australian Research Centre in Sex, Health & Society.

Thumbi P. W. (2008): Kenya country report on reproductive health and reproductive rights, Emphasis on HIV/AIDS. Nairobi: National Council for Population & Development, Kenya.

UN (1995): .Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, New York: United Nations.

UNAIDS (2006): .AIDS epidemic update: December 2006, Geneva: UNAIDS.Available at http://www.unaids.org.

UNFPA (2003): State of the World Population Report. New York: UNFPA.

UNFPA (2004): .Investing in people: National Progress in implementing the ICPD programme Of action, 1994-2004. New York: UNFPA. Available online at www.unfpa.org/icpd.

Varga C. and Shongwe B. (1999): School Based Reproductive Health Education. Durban: Health Systems Trust South Africa,

Wikimedia Foundation, Inc. Wikipedia: The Free Encyclopedia. http://sexeducation.org.

World Health Organization (2004): Unsafe abortion: Global and Regional estimates of The incidence of unsafe abortion and associated mortality in 2000. Geneva, Switzerland: WHO, 4th edition.

APPENDICES

APPENDIX 1

QUESTIONNAIRE

Factors influencing the implementation of reproductive health education in public secondary schools in Uriri District, Migori County

Introduction

These questionnaires have three sections, A, B and C. Section A has 6 sets of questions that will be administered to both teachers and school managers/school administrators. Section B carries 14 sets of questions which would be administered to teachers and school managers and section C which have three sets of questions which would be administered to teachers only. In total there are 23 sets of questions.

Please circle the number of the most appropriate response. Where an explanation is required, use the space provided. The information you give will be used confidentially for the purpose of this study only.

SECTION A: DEMOGRAPHIC DATA (BOTH SCHOOL MANAGERS AND TEACHERS)

1. What is your gender?

    1. Male

    2. Female

2. What is age bracket?

    1. 20-30

    2. 31-40

3. 41-50

4. 51 and above

3. What is your marital status?

   1. Single

   2. Married

4. What is your level of education?

   1. O’ Level

   2. A’ Level

   3. Degree

5. Are you employed by TSC or B.O.G.?

   1. Teachers Service Commission (TSC)

   2. Board of Governors (BOG)

6. What is your profession?

   1. Teacher

   2. Others specify ____

SECTION B: SCHOOL MANAGERS/ADMINISTRATORS AND TEACHERS

1. How is reproductive health education taught in your school? (Select as many options as possible by circling)

    1. As a special session (through guest speakers/Non-Governmental organizations)
    2. Regular teachers (Timetabled)
    3. Integrated/infused in other areas of the curriculum & therefore taught by those implementing that particular curriculum
    4. Others,specify____

    ____

2. In your school you normally implement examinable subjects and non-examinable subjects. Examinable subjects are known while some of the non-examinable subjects are not known please listed below are some of the non- examinable subjects circle as many options as possible you offer in your school.

    1. Physical Education
    2. HIV/AIDS
    3. Pastoral Studies
    4. Others specify____

3. How does the implementation of the examinable subjects and non-examinable subjects influence the implementation of reproductive health in your school? Briefly explain

    ____

    ____

4. What teaching-learning materials do you normally use to teach reproductive health education/sexuality education in your school? (select as many options as possible by circling)

1. Videos/CDs
2. Text books
3. Pamphlets
4. Handouts from the organizations
5. Others (Specify)____

5. Where do you normally get the teaching-learning materials of reproductive health education/sexuality from? (Select as many options as possible circling)

1. Kenya institute of Education
2. Ministry of Education
3. From Non Governmental Organizations
4. Others (Specify)____________________________

6. In your own opinion, how are the teaching-learning materials used for teaching reproductive health education in your school influences its implementation. Briefly explain____
____
____

7. Normally teachers, serve as important resource persons in delivery of the reproductive health/sexuality education for its successful implementation, what are some of their main teaching subjects which you/they normally teach? (Please select, the subjects below by circling)

1. English

2. Kiswahili
3. Mathematics
4. Sciences(Physics, Biology &Chemistry)
5. Humanities (History, C.R.E., geography) specify__________________________
6. Applied subjects (H/science, B/studies, Computer & Agriculture)
7. Others Specify____

8. What other responsibilities do these teachers implementing reproductive health education/ sexuality education have in the school (Please choose as many options as possible by circling.)

    1. Guidance and counseling
    2. Career Masters
    3. Head of Languages
    4. Head of Health/Health clubs &societies
    5. Head of Humanities
    6. Head of sciences
    7. Head of Mathematics
    8. Others specify____

9. There are a number of reasons as to why a teacher may have been assigned the responsibility of implementing reproductive health/sexuality education in your school, some are listed below, (Select as many options as possible by circling)

    1. Initial background training

2. She/he is in-charge of guidance and counseling

3. In-service training

4. As form of punishment

5. Others specify____

10. In your own opinion, how do the main teaching subjects of the teachers, the additional responsibility influences the implementation of reproductive health education in your school? Briefly explain____
____

11. A part from the teachers implementing the reproductive health/sexuality education in your school, who else is implementing reproductive health/sexuality education in your school?
____
____

12. Which church or Organization is the sponsor of your school? (Selects as many options as possible)

1. The Roman Catholic

2. The Seventh day Adventist Church

3. The Angelica Church of Kenya (ACK)

4. The Salvation Army

5. The Maranatha church of Kenya
6. Other churches specify____
7. Organizations please specify____

13. The sponsor of the school be it the church or an organization sometimes supports schools in a number of ways in implementing, the reproductive health/sexuality education. How does your school sponsor support your school in implementing the reproductive health/sexuality education? (Selects as many options as possible by circling.)
    1. Provision of teaching & learning materials
    2. Provision of resource persons to offer reproductive health/sexuality education
    3. Taking students for excursions
    4. Others (specify)____
14. In your own opinion briefly describe how the sponsor be it the church or the organization influences the implementation of reproductive health/sexuality education in your school?
    ____

SECTION C: TEACHERS

15. The reproductive health/sexuality education is not examinable, the school managers/administrators are sometimes biased against its implementation, and they tend to give a lot of priority to examinable subjects. Do you agree with this information?(Select as many options as possible by circling)
    1. Strongly Agree
    2. Agree
    3. Strongly disagree
    4. Disagree

16. Normally school managers provide a number of supports to implementation of reproductive health education; some are listed below, and select those supports which are provided in your school by circling.

    1. Purchase of teaching-learning materials
    2. Provision of funds for outings and innings
    3. Provision of other resource persons
    4. Provision of trainings to teachers and students
    5. Others specify____

17. In relation to school manager's interest towards implementation of examinable subjects and some of the support they offer towards implementation of reproductive health education, how does these influences the implementation of reproductive health education in your school? Briefly explain____

APPENDIX 2

WORKPLAN

NO	**ACTIVITY DESCRIPTION**	**TIME-LINE**	**REMARKS**
1.	Proposal development	December, 2011-May, 2012	
2.	Data Collection	20th,June-30th, June, 2012	
3.	Project Report Development	1st, July-15thJuly, 2012	
4.	Submission of the Final write up	July, 20th, 2012	

APPENDIX 3

BUDGET

NO.	ITEM	DESCRIPTION	COSTS (KSHS)
1.	Stationeries	• hotocopying papers, Foolscaps, Pens, Printing, photocopying services, Typesetting and Binding services	8000.00
2.	Personnel	Research Assistant to be paid Kenya shillings 1500 per day for 5 days	7500.00
3.	Travelling, Communications and other expenses	Transportation costs, Airtimes, Subsistence and contingencies	5000.00
	TOTAL		**20500.00**