

**HEALTH INFORMATION, BEHAVIOUR CHANGE AND TEENAGE
PREGNANCIES IN SECONDARY SCHOOLS: A STUDY OF NAIROBI
COUNTY**

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DECLARATION

I, Judy Nyamvula Amina, hereby declare that this research project is my original work and has not been presented for award of degree in any other University.

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This research project has been submitted under my approval as the University supervisor

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Date

DEDICATION

I dedicate this research project to my family, for wishing this achievement for me.

ACKNOWLEDGEMENT

My sincere appreciation and gratitude goes to my supervisor Prof. Hezron Mogambi for his guidance and intellectual support throughout this research project. I would like to also acknowledge other lecturers whose insightful guidance and support helped me throughout this journey.

ABSTRACT

This study sought to investigate how reproductive health information influences behaviour change among school going young people towards addressing the high rates of teenage pregnancies in secondary schools. The general objective of this study was to investigate the effectiveness of Behaviour Change Communication in addressing teenage pregnancies in secondary schools in Nairobi County through reproductive health information and education. The specific objectives of this study were to; explore the delivery of reproductive health information and education in secondary schools in Nairobi County; assess the contribution of reproductive health information and education in addressing teenage pregnancies in Nairobi County and to find out the issues affecting uptake and utilisation of reproductive health information and education in secondary schools in Nairobi County. This study used the Theory of social change and the Health Belief Model as the underpinning theoretical constructs. Both qualitative and quantitative research designs were used in this study. The study population was young people aged 15-19 years. Simple random sampling method was used to select 66 respondents from 4 schools in Nairobi County to fill out questionnaires and participate in Focus Group Discussions. Questionnaires, in-depth key informant interviews and Focus Group Discussions were the main data collection methods. Quantitative data was analysed using descriptive statistics and presented in form of tables and graphs. Thematic data analysis method was used to analyse qualitative data and presented in descriptive narratives. The study revealed that cultural and religious backgrounds of teachers, parents and students limit delivery and utilisation of reproductive health information and education especially on topics that are considered “sensitive” in the society such as sex and sexual diversities. The study concluded that learners want more reliable information on sexual reproductive health. However, the life-skills education curriculum is not comprehensive and does not address many of the reproductive health issues that young learners go through. The study recommends that through the Kenyan Ministry of Education, the school curriculum should be inclusive of reproductive health education without overlooking any of the issues that are affecting young students in schools. It also recommends active involvement of parents in delivery of reproductive health information to students for their awareness and parental support.

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ABBREVIATIONS AND ACRONYMS

AFIDEP	-	African Institute of Development Policy
BCC	-	Behaviour Change Communication
ESA	-	Eastern and Southern Africa
FGD's	-	Focus Group Discussions
HBM	-	Health Belief Model
HIV/AIDS	-	Human Immuno Deficiency Virus and Acquired Immunodeficiency Syndrome
KDHS	-	Kenya Demographic Health Survey
KNBS	-	Kenya National Bureau of Statistics
LHD	-	Local Health Department
MCH	-	Maternal and Child Health
MDG's	-	Millennium development goals
MoE	-	Ministry of Education
MoH	-	Ministry of Health
NGO	-	Non Governmental Organisation
PLWD's	-	People Living with Disabilities
SDG's	-	Sustainable Development Goal
SRHR	-	Sexual Reproductive Health and Rights Alliance
TPB	-	Theory of Planned Behaviour
UNESCO	-	United Nations Education, Scientific and Cultural Organisation
UNFPA	-	United Nations Populations Fund
WHO	-	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.0 Overview

The background of this study, statement of the problem, the objectives, research questions derived from the research objectives, justification of the study, significance of the study and the scope of the study will be tackled in this chapter.

1.1 Background of the Study

Behaviour Change Communication (BCC) is an approach that promotes and facilitates changes in knowledge, attitudes, norms, beliefs and behaviours. Behaviour Change Communication refers to a set of activities and strategies that promote healthy behaviour patterns. Behaviour Change Communication is also defined as a process of working with individuals, families and communities through different communication channels to promote positive health behaviours and support an environment that enables the community to maintain positive health behaviours.

Globally adolescent pregnancy remains a major contributor to maternal and child death. According to WHO, 11% of all births worldwide are to teenage girls aged 15 to 19 years old (Adolescent Pregnancy, WHO 2018). Pregnancy and childbirth complications are the second cause of death among teenage girls worldwide. In low- and middle-income countries, babies born to mothers under 20 years of age face a 50% higher risk of being still born or dying in the first few weeks versus those born to mothers aged 20-29.

Africa has the world's highest rates of adolescent pregnancy, a factor that affects the health, education, and earning potential of millions of African girls according to a report released by the United Nations Population Fund (Adolescent Pregnancy: A Review of the Evidence, UNFPA 2013). In Kenya, the population is widely made up of young people aged 19 years and below. Those aged 15 years and below form 45% of the country's population (Census, 2009). Nairobi County has a total of 3,134,799 people and 30% of this population is made up of young people below the age of 15 years (NAYS, 2015). Adolescent girls have distinct health and development needs, they are faced by numerous challenges including teenage pregnancy which mostly compromises their health and future. According to the Kenya

demographic and health survey (2014), 15% of teenage girls age 15-19 have already had at least one birth. According to AFIDEP, 17% of women in Nairobi County between the ages 15-19 have begun child bearing and Nairobi County's fertility rate for teenage girls aged 15-19 (adolescent birth rate) is 80 births per 1000 girls (Adolescent Sexual and Reproductive Health in Nairobi County, AFIDEP 2018). The rural-urban difference is minor and shows that early child bearing is almost the same across place of occupation. Nairobi stands at 17% on the prevalence of early child birth in Kenya according to the Kenya National Adolescents Sexual and Reproductive health Policy 2015.

Education is a significant determinant of Sexual and Reproductive Health and Rights especially for girls. Young women who finish secondary school or higher education level have more desirable outcomes on their sexual and reproductive health, are less likely to get pregnant while below age 19 teenage and are more likely to have better socio economic status. Only 25% of the children in the official Kenyan secondary school age are enrolled in tertiary institutions. The poor reproductive health outcomes observed in Nairobi County, can be attributed to the lack of accurate and comprehensive information by both young girls and boys regarding their sexuality and how to avoid getting pregnant from an early age both in school and at home. School health clubs especially in secondary schools are aimed at promoting the health of school children addressing specific health problems that may be of concern in a community, an age group, the country, a particular gender etc. In Kenya, such clubs have been existing for a long time with different catchy names that are most preferred in different schools and settings addressing problems like drugs and substance abuse, HIV and AIDS, unintended pregnancies, sexual and gender based violence etc.

In the context of teenage pregnancies, BCC is an essential part in creating comprehensive interventions that include awareness creation, education, information and service delivery and demand. To enable young people to change their risky behaviours so as to reduce their level of risk in getting teenage pregnancies they must first understand the basic education on sexuality and dynamics of relationships, adopt key attitudes and learn skills and values that can help them to make informed choices and decisions. The young people must also

be able to perceive their environment as supportive of behaviour change and enabling of seeking reproductive health information, clarification and direction.

1.2 Problem Statement

Teenage Pregnancy is the second most common reason for adolescent girls and young women' dropping out of secondary school in Kenya, with 13,000 teenage girls leaving school for this reason each year. The Ministry of Health reports that the prevalence of teenage pregnancies in Kenya was at 18%, in the period between 2014 -2017. The National Council for population and development found out that 378,397 teenage girls aged 10- 19 were presented with pregnancy in health care facilities across 47 counties in Kenya in a period of 1 year (July 2016-June 2017). Rates of pregnancy among adolescent girls increase rapidly with age, from 3% among young women at 15 years old, to 40% among teenage girls at 19 years old (National Adolescent Sexual and Reproductive Health Policy Implementation Framework, 2017-2021).

The Kenyan government has made efforts through the Ministry of Education (MoE) to ensure that young learners are equipped with information and education on reproductive health which is in turn expected to help them make well informed choices about their sexuality. This has been done through the implementation of the Kenya National life-skills curriculum (2008) and the adoption of the Eastern and Southern Africa (ESA) commitment on Comprehensive Sexuality Education and sexual and reproductive health services for adolescents and young people, 2013. Also, the Ministry of Health has in place a National Adolescent Sexual and Reproductive Health policy (2015) which commits to guarantee that adolescents and young people have access to comprehensive Sexual and Reproductive Health information and services and provide for the delivery of reproductive health education in line with the education sector policy on HIV (2013).

Civil society organisations have as well come up with strategies and curricula on reproductive health education to school going students with the aim of empowering them with accurate and reliable information on their health. However, despite these behaviour change interventions in schools in Kenya, the rate of teenage pregnancies and other reproductive health challenges continue to be on the rise or register insignificant changes.

According to a Guttmacher report for 2018, the rate of teenage pregnancy among young women 15-19 years currently stands at 14% which is just a little under the 18% status for 2016/2017 considering the amount of effort put to address this problem by the government and other stakeholders. Teenage pregnancy affects girls negatively on their social and economic status, their families and communities. This usually has a cost on the economic status of a country as they may lose out on the annual income a young woman would have earned over her lifetime, if she had not had an early pregnancy.

1.3 Research Objectives

1.3.1 General Objective

To investigate the effectiveness of Behaviour Change Communication in addressing teenage pregnancies in secondary schools through reproductive health information and education.

1.3.2 Specific Objective

- 1) To explore the delivery of reproductive health information and education in secondary schools in Nairobi County.
- 2) To assess the contribution of reproductive health information and education in addressing teenage pregnancies in Nairobi County
- 3) To find out the issues affecting uptake and utilisation of reproductive health information and education in secondary schools in Nairobi County

1.4 Research Questions

1. What are the delivery methods for reproductive health information and education in secondary schools in Nairobi County?
2. What are the effects of reproductive health information and education to secondary school going students in Nairobi County?
3. What are the issues affecting reproductive health information and education in secondary schools in Nairobi?

1.5 Justification of the Study

This study was necessary because teenage pregnancies continue to be the leading cause of dropping out of schools among women aged 15-19 years. Despite progress made by the Government of Kenya and other relevant stakeholders in ensuring young people receive accurate reproductive health information, young people in this age continue to suffer some of the poorest reproductive health outcomes in the country.

1.6 Significance of the Study

This study findings would provide crucial knowledge in adoption of interventions meant for reduction of teenage pregnancies and strengthen gaps that exist in school health clubs already operational in Nairobi County and setting up of new health clubs in schools that do not have any.

The information found from this study would also be useful to stakeholders in health and education including Ministry of Health, Ministry of Education and civil society organisations in educating secondary school adolescents and young people on their reproductive health. Again, these findings have provided some clarity on what information gaps that exist and aid development of curricula and information that is responsive to such students' needs.

Secondary school going young people especially young women and girls will benefit from identifying clear recommendations that can be used in strengthening their interaction and engagement with reproductive health information in schools and as well get more support from the whole school including their parents and guardians with their access to this information.

1.7 Scope and Limitations

The population of this study was 66 secondary school going students from 4 schools in 4 different areas of Nairobi County. The study on health information, behaviour change communication and teenage pregnancies was geographically limited to Nairobi County and specifically, 4 schools only. Additionally, the study was also limited to secondary school going adolescents aged 15-19 years. This study focused only on reproductive health information which is relayed to students through health clubs in schools and how it has

shaped their behaviour and nothing else. Entry into schools for the research was a challenge for the researcher because of the restrictions placed by the Ministry of Education on interactions of students with external parties considering examination time and period and preparations leading to that, girl's schools

1.8 Operational Definition of Terms

Young People – refers to school going students between the age of 15-19 years who are studying in secondary schools in Kenya

Teenage Pregnancies – refers to pregnancies that occur to girls between the ages 10-19 years, who are still studying in Kenyan schools

School Health Clubs - refers to clubs or convenings in schools where reproductive health information is provided

Reproductive health Information and education - refers to information on sexuality healthy relationships, life skills, gender, sexual rights, sexual and gender based violence

Poor reproductive health outcomes - indicators to the progress of reproductive health specifically in teenage pregnancies, STI's and HIV and AIDS.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

This chapter presents reviews of topics that are related to behaviour change communication and teenage pregnancies. The literature will concentrate on; delivery of reproductive health information and education in health clubs, outcomes of health clubs in addressing teenage pregnancies and challenges faced by existing school health clubs in addressing teenage pregnancies.

2.2 Adolescents and Young People

The Convention of Rights in the children's rights considers everyone under the age of 18 as a child. United Nations, on the other side, defines 'youth' as being aged 15 to 24 years. Young people comprise the largest population in many parts of the developing world. Provision of essential services such as health and education in these regions remains a challenge prompting national and international level policy makers to put in place policies and guidelines to support population growth. With such instruments it is expected that there will be increased investment in the quality of life, meaning that the families' scarce resources can be invested more in the health and education of children.

There is evidence linking population growth and positive reproductive health behaviour such as use of contraception and having accurate information and education on their reproductive health. A population with access to effective sexual and reproductive health (SRH) services is more likely to enjoy better health outcomes. Globally, adolescents of ages between 10-19 years have an unmet need for sexual and reproductive health education which is manifested in adverse reproductive health outcomes including HIV infection and teenage pregnancies.

Sexuality Education in Kenya is currently not a stand-alone, examinable subject taught in schools. Aspects of sexuality education are included in the Life Skills Education Curriculum and divided over other subjects as Biology and Christian Religious Education. The curriculum on Life Skills Education developed by the Ministry of Education in 2002 and revised in the year 2008 includes content on values and skills, coping skills, empathy,

decision-making, communication and negotiation skills. A report published by UNESCO and UNFPA in 2011 found that the syllabi include information that is generally of good quality and deals with behaviours related to sexual health outcomes such as avoiding sex before marriage, preventing sexual coercion, not practicing harmful cultural practices, assertively responding to sexual harassment and sexual assault, bullying and peer pressure (UNESCO, UNFPA, 2011). However, gaps in the syllabi include that information on contraceptives, condoms, sex and sexual health were only superficially addressed and excluded topics as reproduction, Sexually Transmitted Diseases and access and use of sexual health services and sexual diversity.

The Kenyan Ministry of education has an overall goal to improve access to training and education for all Kenyan children, to enhance quality and relevancy of education, reduce inequality as well as leverage on knowledge and skills in science, technology, and innovation which is according to the aspirations of Kenya Constitution 2010, Kenya Vision 2030, Basic Education Act of 2013 and Sustainable Development Goal number 4 (SDG 4) on inclusive education.

With commitments to international and regional instruments on education Kenya has been able to make great steps and take interventions meant to reduce and address the poor reproductive health challenges in the country. Notably, Kenya was part of the 20 countries which affirmed and committed to the Eastern and Southern Africa commitment on Comprehensive Sexuality Education and sexual and reproductive health services for adolescents and young people. Kenya has made progress in this particular commitment by developing national policies and guidelines and as well including life skills education for school going adolescents and young people.

2.2.1 Delivery of Reproductive Health Information and Education in Health Clubs

Kalembo, Zgambo and Yukai (2014), investigated the effectiveness of school health clubs, peer-led health clubs', community-based health programs and health facility-based program effects on knowledge, attitudes and behaviours among teenagers. The study was carried out among Africa sub-Saharan reproductive health programs and employed secondary method of data collection and data was drawn from a 15-year period across 4

data bases and relevant studies. The target population consisted of teenagers of age between 10-24 years which adopted inferential and descriptive statistics for analysis. Findings of the study implicated that education on HIV/AIDS transmissions, condom use, reduction of high-risk behaviour and STI transmissions had an impact on adolescents' knowledge and attitudes. The study concluded that literacy of reproductive health played a key role in reduction of risks associated to risky sexual behaviours, and early teenage pregnancies. Furthermore, a comprehensive approach to reproductive health care should be developed in order to ensure successful delivery of reproductive health care within educational institutions.

Tork (2015) carried out a study in Saudi Arabia investigating the co-relation between reproductive health education offered by school health clubs and attitudes/ knowledge among 14 years and 19 years school going teenagers. The study's target population consisted of 309 students but after purposive sampling structured questionnaires was assigned to 59 students. The study employed use of descriptive and inferential statistics for analysis and for testing hypothesis the Wilcoxon signed rank test was employed. The study revealed that there was a significant relationship between reproductive health education and attitudes and knowledge of the teenagers on their sexuality. Findings further revealed that reproductive health education on menstruation, contraceptive use, early pregnancy, HIV/AIDS and STD and puberty significantly contributed to existing knowledge of the students. The study further implicated that level of literacy and geographical area (rural - urban centered) are positively related to attitude and knowledge among teenagers. Study findings concluded that maintaining a strong focus on community sensitisation and building support among religious leaders, prioritising approaches with the greatest potential to overcome socio-cultural barriers related to unsuccessful delivery of Reproductive health information.

Chau, Chandra-Mouli and Svanemyr (2016) conducted a study on delivering sexual Health Education in Senegalese Education Institution. A multi-pronged search strategy was adopted for data collection and data was drawn from online sources such as African Index Medicus, PubMed, Memoire Online, POPLINE, and Google Scholar. Analysis results revealed that maintaining and strengthening sectoral collaboration between civil society

organisations focused on education and Health ministries will provide an important linkage in ensuring adolescents and school going teenagers receive vital and adequate sexual health information. Findings also revealed that young people can access comprehensive social reproductive health facts when it is incorporated on the school programs. Study concluded that training of teachers, empowering students and leveraging policy environmental opportunities advances and enhances scale up vertically and horizontally on comprehensive health education.

According to Glasier, Gülmezoglu, Schmid, Moreno and Van Look (2016) it is critical for teenagers and young adults to have regular clinical preventive service visits, especially around reproductive health care. Primary care health providers play a significant role in counseling teenagers on various aspects of reproductive and sexual health care. Since sexual attitudes and behaviours change during adolescence, constant discussions are needed to monitor and advice on these changes. In addition discussions on monitoring menstrual cycles, counseling on contraception and prevention of unintended pregnancies are important aspects to the reproductive health care that adolescents receive. Constant and regular comprehensive reproductive health counseling is important for adolescents. When a teenager decides to become sexually active, they need to have knowledge about their options and understand which forms of contraception is best for them. However, many do not feel comfortable going to the health care centers to have such discussions since they are usually met with discrimination from the health care providers. Kenya through the ministry of Health developed national guidelines for provision of youth friendly services in Kenya meant to guarantee easy access reproductive health services at any health center without any discrimination or prejudice from health care providers that caters for all young people.

Mason-Jones (2015) shows it is important to find out and improve effective interventions to help adolescents and young people make informed healthy choices about their sexual and reproductive lives. They found out that adolescents and young people have limited information about SRH and many others face discrimination when they do try to seek RH services and commodities. Alongside education, ensuring that young people have access to a comprehensive package of SRH services delivered in a supportive and respectful

environment is key to empowering young people and preventing poor health outcomes, thus contributing to the Millennium Development Goals on maternal and child health, gender equity and HIV.

Adolescents and young people lack the confidence and skills to negotiate safer sex or plan ahead for contraceptive needs. Hence, education and counselling on RH are critical to making accurate choices about their sexuality. They have worked in partnership with youth organisations, schools, governments and community leaders to empower young people to make informed decisions about their health. Innovative use of new technology and digital platforms offers promising new confidential ways to reach young people. Finally, they ensure that when young people do seek out services, they are met by highly qualified, non-judgmental providers offering services that are affordable to the many young people living at or below the poverty line.

Hughes and McCauley (2018) carried out a research on enhancing the fit on adolescents' needs and sexual and reproductive health programs in developing countries. The study indicated that organisations can play a critical role in increasing access for young people to their sexual and reproductive health and rights (SRHR) including SRHR services and commodities. Since 2000, a number of NGOs have implemented programming with a specific youth focus in 30 countries. In addition to service delivery, they are active in delivery of accurate and comprehensive SRH education, regularly training government and private providers in 'youth friendly' techniques alongside advocacy campaigns to promote and protect the SRH of young people. Simply put, young people want access to services and commodities that meet their needs. A comprehensive context specific to understanding the needs of young people preferences and realities was found out to be the foundation for defining both effective SRH services package as well as the best model for delivery of these services. Getting information directly from young people about what services they need and how they want to access services delivered to them has helped in the design and implementation of youth focused programmes.

Marcell (2017) carried out a study on sexual and reproductive health care services in the pediatric setting. Findings of the study showed that pediatricians are a key source of information on sexuality and reproductive health for adolescents and young adults. Office visits present opportunities to educate adolescents on sexual health and development; improve understanding on healthy relationships and talks on STIs prevention including HIV, unintended pregnancies, and other reproductive health-related cancers; to discuss planning for the timing and spacing of children, planning for pregnancy, and delivering preconception health care, as appropriate; and to address issues or concerns related to sexual function and fertility. Pediatricians can help adolescents sort out whether they feel safe in their relationships as well as how to avoid risky sexual situations. Pediatricians also can facilitate discussion between the parent and adolescent on sexual and reproductive health. Pediatricians are in an important position to identify patients who are at risk for immediate harm (like sexual abuse, CSEC) and work collaboratively to address these needs.

2.2.2 Outcomes of Health Clubs in Addressing Teenage Pregnancies

Robling (2016) conducted a study on the effect of nurse-led initiative programme on first time teenage mothers. The study was conducted in England, which concentrated on teenage parents below the age of 19 years. The study used non-blinded and, parallel-group trial. The study targeted community midwifery setting to identified the rate of less than 19 pregnancies in primary and secondary school children in England. The findings indicated that between June 2009 and July 2010 the number of teenage pregnancies increased. The study indicated that women who have been given family nurse partnership gave birth to normal babies while those that were not allocated a nurse gave birth to underweight children. The study recommends that family Nurse Partnership should be added to provided health and social care provided in order to benefit the health and well-being of the teenage mother and the child.

Klaiman (2016) examined unique practices underway in communities to control maternal and child health (MCH) outcomes. The study employed quantitative data to identify practices that are used by local health organisations department to control maternal and child health (MCH) outcomes. The study was conducted in Washington DC and it

identified 50 local health departments (LHD) to compare with maternal and child health (MCH) outcomes. The findings indicated that partnerships with providers, partnerships for data collection/assessment, and partnerships with community-based organisations were associated with exceptional MCH outcomes based on the interviews. The study concluded that LHDs practices should be implemented to increase or promote MCH outcomes even when there are minimal resources.

Johnson (2016) studied on how to reduce low birth weight. This study was conducted in united national's hospitals. The study used secondary data to identify factors that are associated with low birth weight. The study was conducted on Welsh population. The study calculated population attributable risk. The findings accounted for 14 factors for nearly half of the low birth weight out of this number 60 percent were from young mothers. The findings also associated this with rapid drug abuses that are experienced between teenagers. The study concluded that Risk factors are interrelated and inequitably distributed within the population. Exposure to one factor increases the likelihood of exposure to a constellation of factors further increasing risk.

There are several mechanisms that have been initiated by different organisation to cub the effect of teenage pregnancy. According to Mezey, Robinson, Gillard, Mantovani, Meyer, White and Bonell (2017) study conducted on how to tackle problems that are associated with teenage pregnancies. The study concentrated on after birth effect. The study sought to identify various interventions that have been used to critically address problems associated with early pregnancy. The study looked at the relationship that early pregnancies have on teenage education. The study used group discussion to effectively come to a conclusion on the effect of this problem on teenage lives. The study indicated that there is a significant fall in teenage pregnancies as a result of interventions that have been initiated to manage and control this situation. The study suggested that system should be used to mentor teenagers and should have young people incorporated in them including those who have experienced this kind of challenge before especially in life post-care. The study also noticed that this reproductive health challenge can be tackled easily at an early age thus purporting that sexuality education should be started from an early age. The study

argued that peer mentoring significantly assist teenagers to develop self-esteem, confidence and provide them with the right choices regarding their growth.

Al-Haddabi (2014) conducted a study on obstetric and perinatal outcomes of pregnant teenagers attending a teaching hospital in Oman. Findings of the study showed that teenagers prefer avoiding premarital sex as the best way to avoid teenage pregnancies and STI's. The teenagers thus encourage their peers to hold off and delay intercourse until they are older. The program on postponing sexual involvement places a strong emphasis and focus on abstinence showing that adolescents younger than age 16 are not yet mature enough to handle the consequences of sexual activity. Most of the other curricula are not updated and focus only on abstinence thus failing to equip adolescents with any other information or education on postponing sexual involvement.

Bissell (2016) conducted a study on socio-economic outcomes of teen pregnancy and parenthood. Findings of the study showed that although many attempts have been made to delay adolescent sexual activity and teenage pregnancy ranging from both informal and formal efforts through Youth focused programs. Thus stories of change describing successful programs are often followed by undocumented reports that may or may not confirm that significant changes occurred in the behaviour of the young people who are part of the programme. Because most of these reports are not reported or widely shared, it has been difficult to assess the overall impact of strategies aimed at addressing unintended teenage pregnancy and to inform policy development and implementation regarding which interventions are likely to have the greatest positive impact. Moreover, the lack of proper documentation and reports has led to the replication of programs with undocumented success.

Chandra (2015) conducted a study on pregnancy outcomes in urban teenagers. The study revealed that because most pregnancy prevention programs are made up of more than one intervention, it is difficult to determine which interventions create a difference, or whether all interventions are necessary. In addition, comparisons between strategies and interventions are not usually effective because the number of sessions and the length of the intervention period vary from one program to another. Reducing risks consists of 15 classes

administered during a three-week period. Delaying sexual involvement is made up of 10 classes during a three-month period with the center available continuously to students offering periodic formal presentations throughout the school year. The research further showed that teenagers are getting information on life skills a strategy of many teenage pregnancy prevention programs that are increasingly being recognised as key to their success. Such programmes consist of activities that help students strengthen their decision-making skills, set achievable goals for their lives, learn assertive and negotiation skills within relationships. Activities and meet ups in school often include role-play whereby students act up situations that they may find themselves in.

2.2.3 Challenges Faced by Existing School Health Clubs in Addressing Teenage Pregnancies

Ahumuza, Matovu (2014) investigated the challenges faced by people living with disabilities in accessing sexual and reproductive health services in Uganda, Kampala. Findings of the research show that People Living with Disabilities (PWD's) face an enormous amount of challenges in accessing SRH services including negative attitudes of service providers, long queues at health facilities, distant health facilities, unaffordability of RH services involved, inconvenient physical infrastructures at health facilities and the misconception in the society that PWDs are all asexual. In the same case, adolescents and young people who are living with disabilities experience twice as much challenges when accessing reproductive health services and information and are more vulnerable to sexual and gender based violence.

Dickens (2018) investigated the challenges of reproductive and sexual rights. The study showed that the perceptions of desirable sexual and reproductive health instances seen through the lens of morality raise even more challenges. Sexual education curricula that are abstinence based sometimes pose educational ethics challenges since withhold relevant information on effective ways in protecting against unintended pregnancy and sexually transmitted infections, including HIV/AIDS. Similarly, some health care facilities have been shown to delay urgent care for women who have gone through late-term miscarriage. The priority they afford potential fetal viability risks patient infection and heavy blood loss or patients' trauma in emergency transportation to an alternative hospital.

Mutuli (2014) investigated challenges affecting the implementation of strategic reproductive health programmes among level five hospitals in Nairobi, Kenya. The findings from the study suggested that the level five hospitals face a number of challenges ranging from; slow decision-making process, inadequate resources, cultural interference in some instances, lack of proactive leadership and noninvolvement of all the stakeholders in strategy implementation. In addition, other challenges included lack of commitment from employees in supporting new strategic plans from its development to its implementation and evaluation.

Visaria (2018) conducted a study from family planning to reproductive health: challenges facing India. The study indicated that challenges in reaching adolescents in and out of school with club information and services, lagging fulfillment of women's rights, limited male involvement in the clubs and insufficient progress in maternal health are some of the areas where much focus is needed. While these gains are encouraging, they can only be sustained and expanded with a renewed and heightened commitment by governments, donors, and civil society, bolstered by adequate and predictable funding.

Macdonald (2017) carried out a study on the approach to the challenge of teenage pregnancies. Findings of this study showed that sex education continues to gain importance as a key factor in modern challenges to public health. Teenage pregnancy, with its adverse health consequences on the health and well-being of both mother and child, has reached unprecedented levels in the United States. Despite awareness that comprehensive sex education is essential to addressing these challenges. Discussions currently ongoing have focused on the content and timing of sex education provided in schools, are ineffective. The study showed that sex education curriculums convey the wrong message and are targeted to the wrong audience. In emphasising the provision of information to adolescents, adults ignore the fact that parental guidance and direction are more often helpful than information and opinions gotten from other sources. However relevant bodies and stakeholders fail to provide parents and others who comprise of systems of child care and guidance with the information they require to assume responsibility for the safe and healthy development of children and youth.

Asheer (2014) carried out a study on engaging pregnant teenagers and teenage mothers, challenges associated with early unintended pregnancy and lessons learned from the evaluation of adolescent pregnancy prevention approaches. It was found that cultural practices including traditional dances and cultural beliefs that promote harmful practices interact with lack of knowledge on family planning and poverty coupled with political interference on the position of community relates of child bearing including teenage pregnancy malaise. Pregnancies among teenagers have become common and are on the rise in Kenya. According to (Mumah, Kabiru, Izugbara, C., & Mukiira, 2014) 17% of girls in Kenya have had a teenage pregnancy or a live birth. Education on sexual reproductive health and rights suggest that pregnancies among teenagers may lead to health challenges affecting their psychosocial and mental health. In addition, schools in Kenya have rules that may discriminate on a young mother, for instance a young girl who gets pregnant while still in school may get expelled or face ridicule from both teachers and student once they return to school after child birth. Other schools have restrictions on return to school for young mothers compelling their families to seek for transfers to other schools instead of re admitting them.

Kegler (2015) conducted a study on mobilising communities for teen pregnancy prevention. The research indicated that lack of funds in the communities to start programs and clubs targeting the young people have led to more cases of teenage pregnancies. Additionally, such programmes are mainly supported by civil society organisations instead of the government thus leading to lack of sustainability of the programmes.

Cassell (2015) study on mobilising communities: an overview of the community coalition partnership programs for the prevention of teen pregnancy also came to an almost similar conclusion that governments support to such programmes is not strong. The study showed that if the government would commit and support reproductive health programmes in the community then significant changes would be realised. Teenage pregnancy is a common reproductive health problem worldwide in both developed and developing countries. Although prevention of unplanned teenage pregnancy should be the primary goal the modern society, many adolescents report to have fear or shame in seeking this service.

Ssewanyana (2018) investigated the challenges, young people and stakeholders' perspectives of adolescent sexual risk behaviour in Kilifi County. The results of the study indicated that the local customs and mechanisms are always used in addressing cases of teenage pregnancy. Because of the high number of teenage pregnancies in this county, the government issued a ban over traditional dances popularly known as "*disco vumbi*" in pursuit to reduce the cases of teenage pregnancies in the area. Unfortunately, the health centers in Kilifi County do not have youth friendly services for the young people thus leading to lack of safe spaces for young people to express themselves and to freely seek for reproductive health services.

2.3 Research gap

Review of literature suggests that there has been an increased focus on the relationship between Health information among adolescents and the decisions they make about their sexuality. Prior studies have generally found a positive relationship between the access of reproductive health information and education by adolescents and their sexual health behaviours and choices (Kalembo, Zgambo and Yukai (2014), Tork (2015), Xhau, Chandra–Mouli and Svanemyr,J (2016). However there are also studies where such relationship has not been established specifically between the rising cases of teenage pregnancies and reproductive health information. Consequently more research is needed in this area.

2.4 Theoretical Framework

2.4.1 Social Change Theory

The theory of social change by Thibaut and Kelley (1959) is a social psychological and sociological perspective explaining social exchange between parties. The theory explains the relationships of people either individually or even in a group, the behaviour and the interest of the people. The theory holds that social changes are defined by the costs and the benefits of the interactions. There is a cost benefit analysis to the interactions. The theory was further advanced by (Homans, 1961) who in his argument emphasised on the individual behaviour of people in the interactions with each other. Homans had three key concepts of social change that he looked into:

The success proposition- when one is rewarded through the interaction process and their actions are of benefit, they repeat the action; stimulus proposition- if a given stimulus has resulted to reward then response to the stimulus in future is instant. People are reward oriented. Deprivation- if the reward becomes too frequent then the value for the reward diminishes and the drive towards the reward lowers.

Mitchel (2005) argues that social change theory is about the reciprocity rule where it is payment in kind that matters. Positive actions are reciprocated with positive actions while negative actions are reciprocated with negative actions. In his argument, he states that in social change people only consider what benefits them and no one is willing to lose.

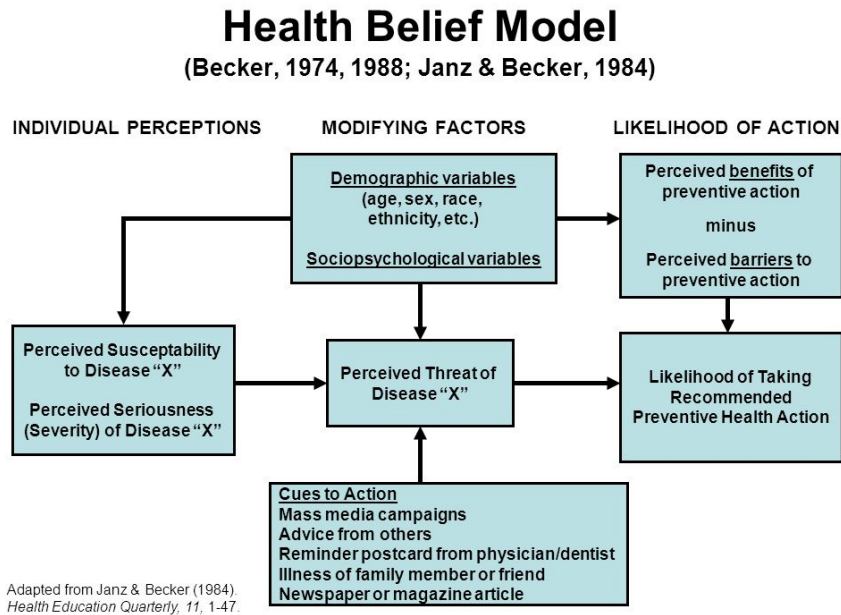
According to Hothouse (2013), human beings engage on social changes only to maximise their outcomes. There has to be a weight between the costs and benefits in order to define the outcome of the social change. Social Change Theory which has three phases namely: the expectations level, comparison level and the comparison level of alternatives.

The above theory is therefore a sign of the impact of behaviour change communication in delivery of reproductive health information and education. This theory shows and supports that once the target population understands the outcomes of putting into practice the reproductive health information and education, they receive then they would be more willing to change them.

In this case, the stakeholders would not only involve the young people but the government, schools and the community at large. Therefore, this research mainly used the theory of social change as a theoretical framework, because of the very nature the research approach of the study appears suitable for the theoretical foundation of social change for development.

2.4.2 Health Belief Model

Figure 2.1: Health Belief Model



This theory is relevant in determining the behaviour of young people in secondary schools and their uptake and utilisation of reproductive health information and as it indicates one's behaviour is dependent on their risk/benefit analysis or their analysis of the cost and benefit of adopting a certain behaviour (Naidoo & Wills, 2005)

The following factors affect one's ability to adopt a health prevention behaviour according to the HBM; Perceived susceptibility which means that people will only change their behaviour if they believe themselves to be at risk; Perceived severity which means that the ability of one to adopt a behaviour lies within their assessment of how severe the consequences of not changing their current behaviour is; perceived barriers which is the assessment by a person of how hard adoption of the behaviour will be and perceived benefits meaning people are more likely to adopt a behaviour if they see there is something in it for them to adopt that behaviour (Becker, 1975)

Media in Kenya has been evolving at a high rate over time. According to the Kenyan Communications Authority, internet penetration was at 90% as of September 2017. As of 2012 the Media Council of Kenya reported that Kenyans use radio as the main source of news and information at 83% and Television coming in second at 35% (State of the Media Report, 2018). Young people both in and out of School have an easy access to communication devices including mobile phones and are able to access all manner of information. A study done by Kiarie Anthony in 2016 revealed that media especially contributes to teenage pregnancy among secondary school students because of the exposure they get on sexually explicit content both on mainstream media and electronic platforms. Evidence suggests that displays of sexual material on Facebook are associated with the reported intention to become sexually active among teenagers (Connell et al, 2009). This means that young people require guidance in their consumption of communication content regardless of the channels used. As minors, they may not have the ability to sieve out what is suitable for them and what is not.

HBM recognises that the fact that someone may want to change a behaviour or adopt a certain disease prevention behaviour doesn't mean they will automatically adopt that behaviour creating need for additional factors that could nudge one into changing their behaviour. These include; Self efficacy and cues to action.

Cues to action are external factors or events that prompt someone to make health behaviour change and could range from media health promotion messages or listening to someone's experience about having adopted a particular behaviour, or even having someone close to you be affected or die from a particular disease for example in this case a friend or a close relative dropping out of school because a teenage pregnancy or lose their life because of birth complications may make one wish to adopt prevention behaviours towards teenage pregnancies (Becker, 1975). The Concept of Self Efficacy was added to the HBM in 1988 and looks at an individual's belief in his or her ability to adopt particular behaviour or make behaviour change (Montanaro, 2014), (Conner&Norman, 2005)

Practically the theory argues that for a young person to utilise health information they receive in school or at home is dependent on whether they think of themselves at risk of getting pregnant or getting someone pregnant, their anticipation of how severe the consequence it is for them to get pregnant and the benefits of utilising the health information they receive. Self-efficacy which is the belief of the young person in their ability to utilise the health information they receive in school as well as other external factors like cultural and traditional messages influence on teenage pregnancies and sexuality, religious teachings, peer influence etc.

Bandura argues that all humans have the ability and capacity to exercise control over the nature of one's life. This in essence is one's agency to make choices that Health promotion is important for shaping behaviour of both boys and girls when it comes to addressing teenage pregnancies. Policy makers and program implementers should maximise impact through engaging young people in participatory approaches for developing and implementing health promotion information and education that is responsive to their realities and needs they deem good for them. (J.Barnes, 2009)

In making these choices, however, one is influenced by the levels of information given as well as how the environment they exist in will be supportive of their agency and choice (Bandura, 2001). This is supported by a study comparing HBM and TPB theory based condoms intervention that found that constructs that explain behaviour are not the same as those that produce behaviour (Montanaro, 2014).

2.5 Conceptual Framework

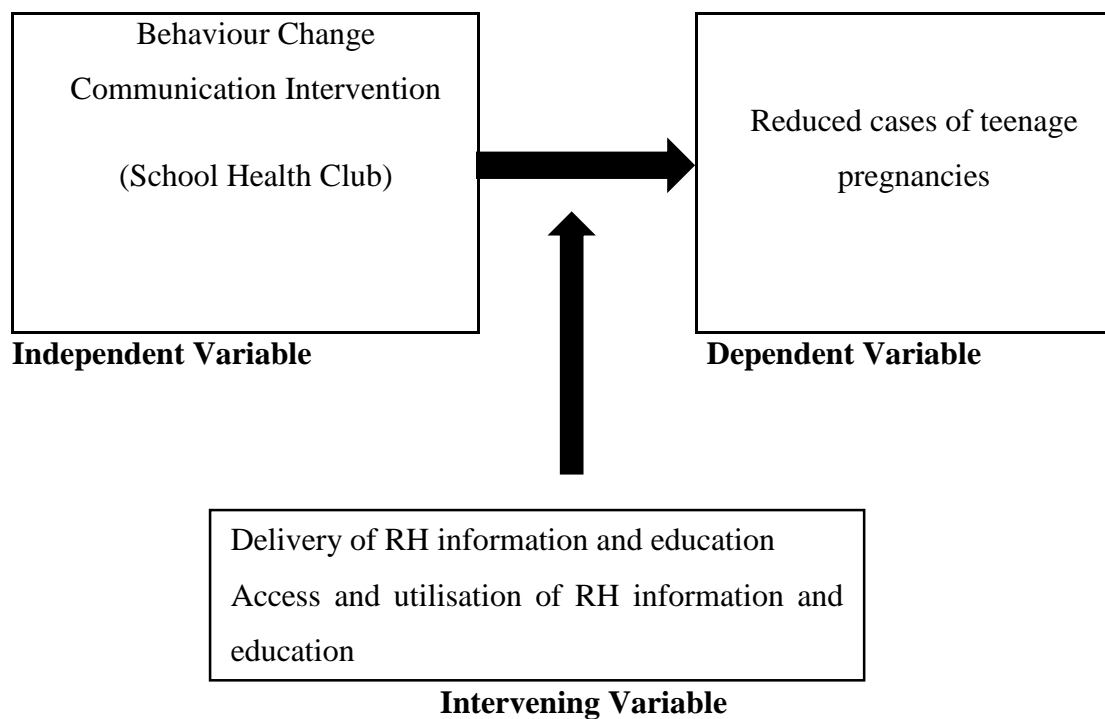


Figure 2.1: Conceptual Framework

Source (Author 2019)

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

This chapter discusses the research methodology that guided the study. This includes the research design, population and sampling, data collection, reliability and validity of the instrument, data analysis and presentation, and ethical considerations.

3.2 Research Design

This study adopted the use of descriptive research design. Descriptive research design provides an accurate account of characteristics of particular individuals, situation or groups leading to discovering new meaning, describing a particular phenomenon and how people respond or adapt the behaviour (Dulock, 1993). The design fit with the study which looked to investigate the effectiveness of Behaviour Change Communication in addressing teenage pregnancies in secondary schools in Nairobi County through reproductive health information and education.

3.3 Research Approach

The study used a mixed methods approach which was relevant to the study as data was collected using questionnaires and focus group discussions with 66 secondary school going students and 6 key informant interviews with teachers or patrons responsible for the health clubs in the schools, the reproductive health coordinator from Nairobi County and the principle education officer from the Kenyan Ministry of Education. Therefore the study utilised both qualitative and quantitative research methods thus allowing both the frequency and the possible explanations for findings to be explored.

3.4 Research Method

This research was a case study of four secondary schools in Nairobi County. According to (Yin, 1984) a case study is an empirical examination of a contemporary existence in a real context in situations where it is not clear what the existing boundaries between the phenomenon and the reality are not very clear. Case studies rely on numerous evidence sources

3.5 Population and Sampling

A sample is a sub-set of the population drawn through a definite procedure. Some studies entail a large population which cannot all be studied therefore it is important to have a portion of the population. The sample should contain the elements and the characteristics of the population being studied (Banerjee, 2010).

The population of this study was 4 secondary school health clubs in Nairobi County which the study targeted 18 students per health club in every school purposively selected from form 1 to form 4, 1 teacher/patron responsible for the health club per school .

According to the 2014 Kenya National Bureau of statistics (KNBS), Nairobi County has a total of 321,024 young people enrolled in secondary school education (Male-135,947, Female-185,077). The study focused on 4 schools in 4 different areas of Nairobi County. A preliminary research was conducted to identify schools in which Reproductive Health Information and Education is being offered to the students in the different areas of Nairobi County. Eastleigh Boys High School in Kamkunji Constituency, Nairobi Milimani Secondary School in Dagoretti North Constituency, Samaritan Educational Centre Mixed secondary school in Dandora, Embakasi North Constituency and Shilce Mixed secondary school in Dagoretti South Constituency were purposively selected as they provide reproductive health information and education to their students. According to the number of KCSE candidates per county, these schools are in areas with a large number of young people i.e. (Kamkunji 1180, Dagoretti 1445 and Embakasi 607 young people sat for the KCSE in the year 2014). This areas also have cases of high teenage pregnancies and STI's which is representative of the other different sub counties in Nairobi. Government officials from Nairobi County department of adolescent health and the Kenyan Ministry of Education will also be targeted by the study. A sample of 66 students, proportionately distributed across the four schools was used for the study. To get these respondents the researcher visited the selected schools to access the secondary school health clubs.

Purposive sampling method was used to identify the four schools in Nairobi County to take part in the research and further the researcher and further the researcher used simple random sampling to draw students from the different education levels in secondary schools

to take part in the FGD's from the 4 school health clubs. Purposive sampling method was used to select 6 key informants comprising of 4 teachers or patrons responsible for the health clubs, from the reproductive health coordinator of Nairobi County and the principle of education from the Kenya Ministry of Education.

3.6 Sampling Procedures

This study used both probability sampling and non-probability techniques. It employed simple random sampling procedures which enabled selection of samples that possess the characteristics and the qualities that are viable for this research work (Creswell, 2014). This process involved getting a full list of the students who are part of the health club from form 1- form 4 and randomly selecting study respondents. A total of 36 respondents were selected in 4 schools to fill out questionnaires. While 30 of them participated in FGD's. To reach them, the researcher had prior meetings with school heads of each school and had a discussion with them together with the patrons of the health club informing them of the study. Any questions regarding the study were answered and clarified.

Purposive sampling which is a non-probability sampling technique was also employed in the selection of the 4 schools which already have Reproductive health programmes offered. This schools included Shilce Secondary Schools, Nairobi Milimani Secondary School, Eastleigh Boys Secondary School and Samaritan Educational Centre. Teachers or patrons responsible for the health club were also purposively selected from the 4 schools which were part of the study for in depth Key Informant Interviews. Selection of officials from the ministry of education and Nairobi County department of adolescent health was also done purposively targeting individuals who have interacted with adolescent health and development of educational guidelines and policies. Purposive sampling was ideal for this study because of its ability to get in-depth data from key individuals and from school-going respondents.

3.7 Data Collection

In this study, focus group discussions and key informant interviews were used as the main data collection method. The study was based on primary data collected using questionnaires and focus group discussions (FGDs) with secondary school students who

are part of school health clubs and interviews with the key informants. A focus group questions guide with open ended questions was used (annex B). This ensured that the respondents were not limited in their provision of information. This study held 4 focus group discussions with a total of 30 participants. The participants were all school going young people between the ages 15-19 years identified from the 4 secondary schools in Nairobi County.

Structured interview schedule with open ended questions as well was used for the key informant interviews (annex C) with a total of 4 key informants. Participants for the key informant interviews were individuals with key leadership within the Ministry of Education, Nairobi County department of adolescent health and teachers in charge of the school health club and/or in charge of health in the school. Closed ended questionnaires (Appendix D) were administered to secondary school going young people which sought to gather more information on the extent to which reproductive health information and education influences the behaviours of school going young people in addressing teenage pregnancies. The questionnaires were administered to a total of 36 young people in secondary schools who have interacted with reproductive health information and education in their school health clubs. The use of questionnaires as one of the data collection method is significant since it gives valid results (Kothari, 2004).

The interviews were conducted in schools from which the learners studied at schedules and time which were convenient for the school and the students. The proceedings of the interviews were audio-taped and transcribed. To protect the participant's privacy, pseudonyms were assigned for each participant during the interview transcription.

The researcher contacted the targeted schools, through one on one talks with school heads. A data collection request letter, duly approved by the University, was attached to the interview schedule and focus group discussions question guide, as a way of introducing the researcher, explaining the objectives of the study and guaranteeing confidentiality to the respondents.

3.8 Reliability and Validity of the Instrument

Validity and reliability of the instruments to be used during the study will be done using a pilot study to test whether the interview guide and the FGD guide is clear, understandable and easy for respondents to interpret.

The interview and FGD guide will also be subjected to a review by the researcher's supervisor who will advise on any further changes and recommendations on the instrument to ensure their validity.

3.9 Data Analysis and presentation

The study employed descriptive analysis methods. This type of analysis is used in both quantitative and qualitative techniques applied in any research. Quantitative data from the questionnaire was coded into the computer for the computation of descriptive statistics. The Statistical Package for Social Sciences (SPSS version 20) was used to generate descriptive statistics. The results were presented in form of tables, charts and bar graphs. Findings from the qualitative data generated from the open-ended questions in the focus group discussions and key informant interviews analysed were arranged through content analysis by organising data into themes and information presented in prose form connected to the literature review findings and discussions and aligned to the objectives of the study.

3.10 Ethical Considerations

Prior to conducting the study, the researcher sought approval from the University of Nairobi School Of Journalism upon which she was issued with a Certificate of Fieldwork (Appendix 5). The nature of this study required an approach with great sensitivity, since it engaged and interacted with young people under the age of 18 who are considered minors by law in Kenya and also focuses on reproductive health which is as well a sensitive topic.

The participants who took part in the study were informed about the aim of the study and probable benefits, assured that their participation in the research would not cause them any harm, ridicule or unfair treatment in their schools. Participation in the research was voluntary. At the beginning of each FGD and interview participants were assured of confidentiality, the manner in which responses would be recorded and a request made for the participants' consent to record the interview. Where participants were uncomfortable

with recording, the recorder was not used and hand-written notes of the interview were instead recorded in a notebook. Participants were reassured that they could stop the interview at any point they want to without need of any further explanation. The importance of maintaining confidentiality was emphasised during the assessment process. No names were recorded during report writing.

Consent forms for both the students and their parents (appendix 1) were explained in English and Kiswahili languages and signed by the participants before the start of every interview. Parents of the students who participated in the study were informed about the research by responsible teachers prior the interaction with the students and agreed to their participation, consent forms for the parents were signed on their behalf by the teachers. Upon successful defence of the project, the researcher was issued with a Certificate of Originality (appendix 6) after meeting the required threshold for plagiarism in line with the University Regulations. The researcher was also issued with a Certificate of Corrections (Appendix 7) by the School of Journalism and Mass Communication after incorporating all corrections by the defence panel.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Overview

This chapter presents analysis of data and interpretation of the findings. The data analysis and the interpretations were done as per the objectives of the study. This chapter therefore flows from the study objectives; to explore the delivery of reproductive health information and education in secondary schools in Nairobi County, to assess the contribution of reproductive health information and education in addressing teenage pregnancies in Nairobi County and To find out the issues affecting uptake and utilisation of reproductive health information and education in secondary schools in Nairobi County.

The study used both qualitative and quantitative methods of analysis whereby in qualitative analysis, data was collected through 4 focus group discussions in 4 different secondary schools and key informant interviews with 4 teachers who are patrons of their school health clubs, principle of education for the Ministry of Education and the Reproductive Health Coordinator of Nairobi County. Quantitative data was collected through questionnaires to secondary school going students in the four schools. The collected data was summarised through descriptions of graphs, tables, pie charts and themes.

4.2 Response Rate

The anticipated sample size of secondary school going students to fill in the questionnaires for quantitative data was 40. A total of 36 questionnaires were filled and returned to the researcher thus demonstrating 90% response rate. For the Qualitative data collection, the study anticipated to conduct four Focused Group Discussions (FGD) with 8 participants in each group and conduct 6 interviews with key informants. All 6 key informants were reached and a total of 30 students participated in the FGD's. The overall response rate was above the recommended threshold of 75% and provided sufficient empirical data for analysis (Baruch, 2008).

4.3 Demographic Presentation

The demographic characteristics captured from the respondents include; gender, age, class level, and religion. The inclusion of demographic characteristics provides the researcher with the understanding of how particular characteristics influence the understanding of the reproductive health information by the respondents and their behaviours thereof. More than half of the respondents (53%) were women while 47% were men as shown in Table 4.1.

Table 4.1: Gender of Students in the Health Clubs

Gender	Frequency	Percent
Male	17	47.2
Female	19	52.8
Total	36	100.0

4.3.1 Age

This study targeted secondary school going students aged 15-19years. In order to better understand the perspectives of the students, the study sought to analyse the age of the study respondents and participants. More than half of the study respondents (87.76%) were aged 20-24 years while 12.24% were aged 18-19 years.

Table 4.2: Age of Students in the Health Club

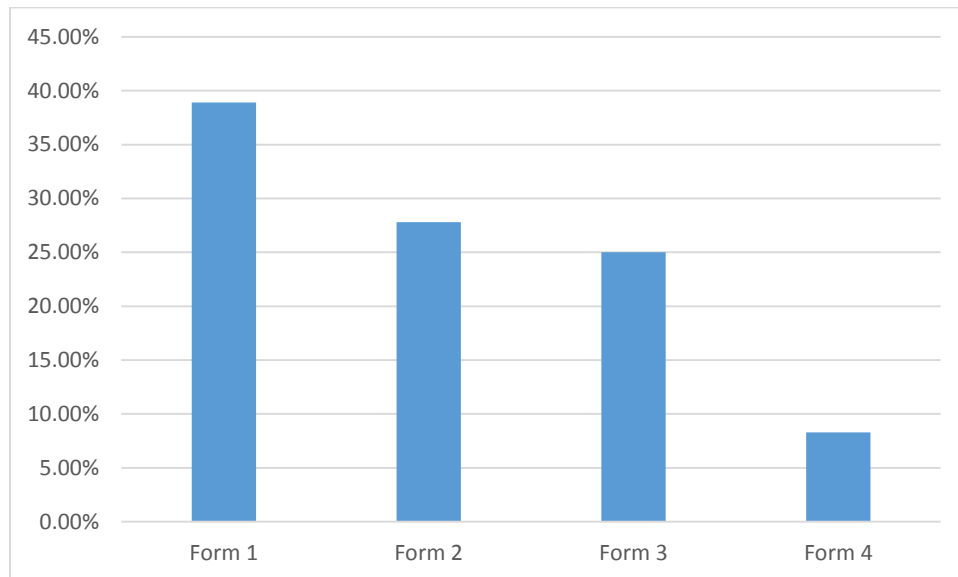
Age	Frequency	Percent
15-19	34	94.4
20-24	2	5.6
Total	36	100.0

4.3.2 Class Level

Figure 4.1 shows that majority of the study respondents in this study was made up by form 1 students with 39% representation. Majority of the respondents (31%) were in form 2, 25% in form 3 and only 6 % in form 4. Understanding the student's class level of education provides an understanding of how long they have interacted with reproductive health

information and the role of the education they received in making decisions about their sexuality.

Figure 4.1: Class Level of Students in the Health Club



The evidence of the role of reproductive health information and education in addressing teenage pregnancies and improving other reproductive health related outcomes of adolescents and young people is well established and acknowledged. Adolescents who have access and receive reproductive health information and education tend to make well informed decisions about their sexuality thus staying in-school longer and reducing cases of school drop-outs. Some studies have also concluded that literacy of reproductive health played a key role in reduction of risks associated to risky sexual behaviours and teenage pregnancies (Kalembo, Zgambo and Yukai (2014). Students who have had access to RH information and education present themselves with confidence and are at a capacity to educate and advise their peers on such matters. According to respondents from the FGD's, they have gained respect among their peers in school from the information they have provided them with, in addition it has also helped shape their behaviours and they have become more responsible and disciplined. This as well agrees with the Social Change theory which this study is anchored upon, the respect the students receive from their peers is the benefit they receive from the interaction at the school health club and therefore more

motivation to continue their participation in the health club. In addition, the fact that their peers view them as more knowledgeable and able to advise them on their personal matters further enables them to continue being part of the health club and learn more on reproductive health issues.

Q: What do you like about your involvement in the club?

“Vile tulimaliza lessons za kwanza tuli introduciwa assembly to the whole school na since then hua tunapewa respect.” Respondent 1

(When we finished our first lesson, we were introduced to the whole school during assembly and since then we are respected)

“Yaani ni kama sisi ni madaktari lakini si wakutibu wakupeana SRHR information tu.

(We feel like doctors but not to treat people but to share SRHR information only)” Respondent 3

“Last year I was given a suspension because of bad behaviour in school but since I joined the club I know I have responsibility and other people are looking at me. Now I’m disciplined na sijapewa suspension tena” Respondent 4

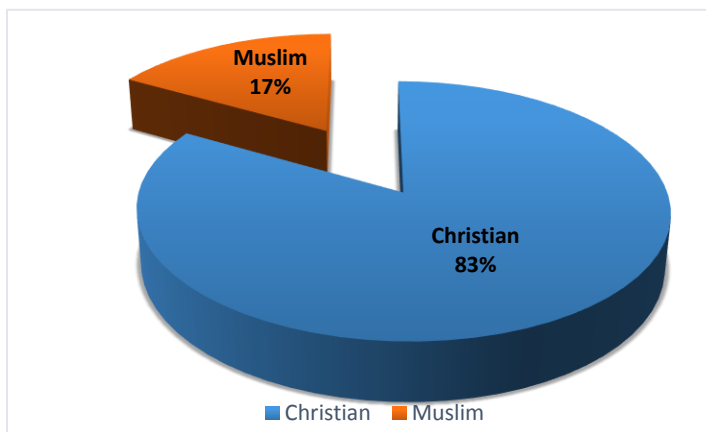
(Last year I was given a suspension because of bad behaviour in school but since I joined the club I know I have responsibility and other people are looking at me Now I’m disciplined and I haven’t been suspended from school again)

Almost all of the respondents attributed to their discipline in school to the education they get from the health club. The teachers also shared that some of the topics they cover in the clubs include body changes, peer pressure and self-esteem which has helped the students to cope with the changes in their body and their environment both at school and in their homes and as well has contributed to their behaviour in school as they are more disciplined and focused.

4.3.3 Religion

Religion affects how individuals relate to others and how they perceive information shared to them and their settings. More than half of the students who took part in this study (83.3%) were Christians while only 16.7% were of Muslim religion. The students who were Muslim shared that when they joined the health club, they found it quite difficult to hold discussions with the other club members and the patron on some of the topics such as sex and relationships they cover in their health club because they have grown up knowing that it is “haram”

Figure 4.2: Religion of Students in the Health Club



Conservative faith based beliefs and liberal understanding of sexuality or reproductive health information and education have always clashed. For instance, globally there is a persistent debate on implementing an abstinence only until marriage sexuality education curriculum versus a comprehensive sexuality education curriculum (Santelli et al., 2017). Conservative countries and religious groups always use religious and cultural arguments mixed with other sentiments such as the forceful adoption of western culture by Africans to discredit the importance of reproductive health education. Generally opposition against reproductive health information and education is diverse however most of the time religion and particularly Christian and Muslim values are frequent reasons why governments, parents and other independent bodies show opposition against reproductive health information and education (Rutgers, 2018).

4.4 Operation and Running of Health Clubs in School

The Ministry of Education expects every school to have an active health club which is meant to address all health challenges faced by the students in school including RH education and other issues that are affecting them. However much this is a requirement by all schools the principle of education from MoE provided information that only about 20% of the schools in the country adhere to it. There has as well been slacking from the MoE itself as they have not done any follow ups to know how many health clubs exist and why most schools do not have any active health clubs. Almost all of the students who filled the questionnaires (34 out of 36) were part of health clubs in their schools making 94% of all the students who took part in the study. Health clubs have been proven to be an effective strategy in delivery of reproductive health education (Donna.M.Denno 2015). Health clubs provide a safe space where students are able to share their views without judgment or ridicule and promote uptake and utilisation of reproductive health education. Such findings agree with this studies as students who took part in the research agreed that the health clubs are beneficial to them and their friends.

4.4.1 Meeting and Sessions for the Clubs

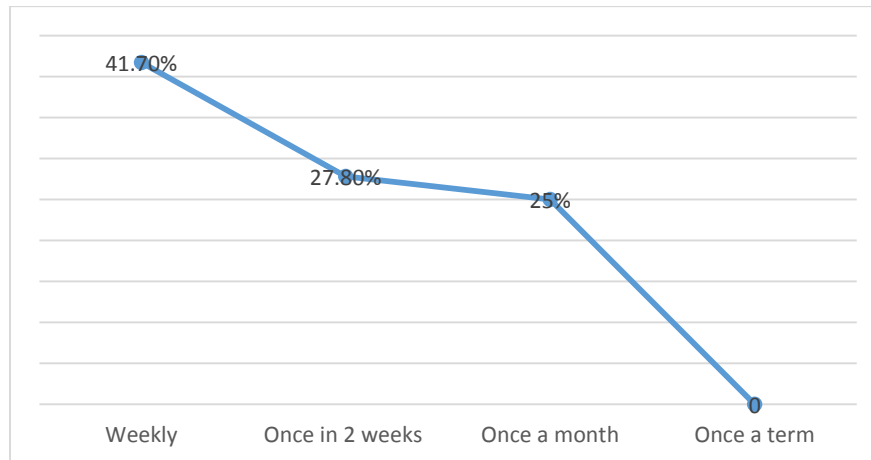
Some of the students (15) reported to meeting at least every week in their health club. None of the students reported to meeting once a term therefore from the 36 respondents the health clubs seemed to meet frequently. The patrons of the health club shared that frequent meetings help to keep the interest of the students and did not give them time to forget the topics they have already covered. Since Life Skills Education as a subject is not examinable, very few teachers are willing to even take up the role of patron for the health clubs. One of the teacher's shared:

“It requires a lot of dedication since I have to hold the lessons after working hours and I do not get paid any extra for overtime” Teacher, Samaritan Educational Centre

Similar to this, several studies have shown that well trained and motivated teachers are key in delivery of quality reproductive health education (Michielsan et al 2010, Shepherd et al 2010, Rutgers 2018). Studies have also shown that there is lack of guidance on teaching

reproductive health education to students by the curriculum and they are also not able to properly integrate this education to existing examinable subjects even in other regions. In addition, there's limited prioritisation of reproductive health education by governments (Joseph Mumba Zulu, 2019) which in turn does not help in motivating teachers to handle the reproductive health topics.

Figure 4.3: Frequency of Meetings in the Health Clubs



The students reported to covering a number of topics and from the questionnaires. Majority of the students reported to have tackled lessons relating to HIV and AIDS, teenage/early pregnancies and Sexual and reproductive health. From the FGD's the students mentioned that they also cover topics regarding to sex such as the effects of engaging in sex while still in school and peer pressure.

Table 4.3: Topics Tackled in the Health Clubs

Topics Tackled in Health-Club	Responses	
	Frequency	Percent
Teenage Pregnancy	15	24.2%
Drug Abuse	11	17.7%
Sexual and Reproductive Health	15	24.2%
Contraceptives	2	3.2%
HIV and AIDS	19	30.6%
Total	62	100.0%

A few students mentioned that some of topics they cover sometimes make them feel uncomfortable as illustrated by an excerpt from the FGD below;

Q: Are there any topics covered in your clubs that you find difficult to have a discussion on?

“Me hufeel uncormfortable tukiongea about sex. Ju sisi ni watoto tunapata shida kuongea juu ya hiyo story” Respondent 5

(I feel uncomfortable when we talk about sex because we are children and we have a hard time talking about such things)

“Topic ya abortion ilikua ngumu kwangu during lessons but sahhh, I’m more comfortable and I tell my friends who get pregnant not to have an abortion because it could harm their health.” Respondent 2

(The topic on abortion used to be difficult for me but I’m now more comfortable and I can tell my friends who get pregnant not to get an abortion because it could harm their health)

“The topic on relationships was difficult for me at first because we never spoke about it with elders but only amongst ourselves” Respondent 3

According to the principle education officer from the ministry of education, life skills education which should be offered to all public schools is supposed to cover topics that cover all aspects of a young student’s life including reproductive health. However, since the subject is not given much importance by teachers, students do not get to have all this lessons. In addition, the official from the ministry confirmed that the Life skills education curriculum is not comprehensive when it comes to covering RH issues. This was further confirmed by the 4 teachers interviewed as key informants who mentioned that they had to integrate the life skills education curriculum with others provided by Civil Society organisations since it is not comprehensive on its own. This is further backed up by a study conducted by Unesco and UNFPA in 2011 which found out that the life skills education syllabus by the MoE deals with only behaviours related to sexual health outcomes but do

not include information on contraceptives, condoms, sex, sexual health and access to reproductive health services.

The RH coordinator of Nairobi County shared that it is a failure by the MoE for having a curriculum that does not address RH issues that affect young learners.

“We have buried our heads under the sand and assume that our children will not face any of the RH challenges that their peers face” RH Coordinator, Nairobi County

She further explained that, for the curriculum to work they would have to involve the learners as well at the development stage so that the issues covered are not based on assumptions of what they want to learn but on true reflections of the challenges that the learners face.

The teachers also mentioned that they find some topics difficult to handle with the students and with further exploring, the researcher found out that this was because of their setting, religion, culture, personal beliefs and principles. Such topics included; sexual diversity, abortion, masturbation and sex. Two of the teachers interviewed have been giving RH information for almost 10 years and they admitted that when they started teaching their students these issues they couldn't handle specific topics but overtime it has become easier for them to speak to their students on any issue. Similarly, the students mentioned difficulty in having discussions on topics such as sex. This is mainly attributed to their upbringing whereby culture dictates that some topics such as sex are not to be discussed openly and more so not by children. In addition, in many communities discussions around sex and reproductive health are not allowed before marriage and is seen as dangerous and harmful to the young unmarried people. In other communities, it is also believed that conversations around reproductive health are intended to promote immoral behaviour (Svanemyr et al., 2015). Because of such cultural constructs, there's difficulty and discomfort among both teachers and students to tackle certain topics.

Majority of the students shared that information in the health clubs is delivered to them through group discussions as illustrated by table 6. This information is usually provided to them by their club patron or sometimes peer educators or guest speakers. The official from the ministry of education informed the researcher that the ministry requires every school to have a trained counsellor who can handle issues affecting the students' health and wellbeing. However it hasn't been the case throughout as there are very few teachers who have been trained as peer counsellors and therefore many schools lack a trained and professional counsellor.

Table 4.4: Delivery of Topics in the Health Clubs

Mode of Delivery	Responses	
	Number	Percent
Role Play	16	29.6%
Group Discussions	29	53.7%
Lecture	2	3.7%
Guest Speaker	7	13.0%
	54	100.0%

From further follow up in the FGD's, some of the students also added that their patrons allow them use their talent to demonstrate their understanding of the topics they have covered. For example they compose poems and come up with skits and songs on the topics they have covered. Some of these items they come up they present to the school during events such as Thanksgiving Day. Others also mentioned that their patrons use real life events to help them understand better. The teachers interviewed further built up to these findings by informing the researcher that they like to have interactive discussions with the students which helps them to open up about their own issues and those that their friends could be facing. The students find the lessons more enjoyable when it's done differently from the lessons they handle in class. Another teacher shared that in their school they have also incorporated the use of computers so as to build the IT skills of their students while at

the same time giving them reproductive health information in a relatable and easy to understand way. Students respond better to interactive teaching methods which allow for open and honest discussions with their teachers and fellow students (Hussein Haruna, 2018) thus contributing to effective delivery of reproductive health education.

4.5 Support for the health Club

Patrons in the health club sighted different areas where they receive support for running of the health club and where they face challenges and opposition. One of the teachers who is in a Muslim dominated school said he gets a lot of resistance from parents who believe a Christian should not teach their children as they mislead them and make them go astray. However, the teacher ensures that all parents are aware of the health club and its benefits and that their children are part of it. He has received complains informally through the students when they share with their parents about their involvement in the club but no official complaint has been made. Another teacher who like the others has partnered with a civil society organisation to get better content for his club shared that the school management is not very supportive as they feel there are other pressing issues the students have as opposed to RH and other teachers find it a waste of time as they have to work overtime and do not get reimbursed for this anyhow.

From the questionnaires, 69% of the students said that their parents approve on their involvement in the health club as shown in the table 4.5, while about 25% of the students chose not to answer that question.

Table 4.5: Approval from Parents for Students Participation in the Health Clubs

Approval for participation	Frequency	Percent
No Answer	9	25.0
Yes	25	69.4
No	2	5.6
Total	36	100.0

The students mentioned that they receive more support on their involvement of the health club from their teachers followed by their parents, friends and schoolmates. They however cannot share with their parents all the content of the issues they address in the health club lest they are told to stop being part of it. One of the students shared that once their neighbor told her that she has bad manners when she heard her tell her friends as they were playing that they should abstain from sex until they finish school.

‘Jirani yetu alisema mimi niko na tabia mbaya ju alinisikia nikiambia rafiki zangu tuabstain’ Female Student, Samaritan Educational Centre

(Our neighbor said that I’m indisciplin because they heard me telling my friends to abstain).

Table 4.6: Support for Involvement in Health Clubs

received	Support	Responses	
		Frequency	Percent
	Parents and Guardians	15	22.1%
	Teachers	31	45.6%
	Friends	12	17.6%
	Schoolmates	10	14.7%
	Total	68	100.0%

With further discussions with the students, they mentioned some of the reasons why they cannot speak to their parents about some of the topics they cover as shown in excerpt below;

Q; Why are you not able to tell your parents about topics you cover in your club?

“Kuna vitu huwezi ongesha wazazi kuhusu wataona hauko disciplined”

Respondent 2

(There are things you can’t talk to parents about because they might think we are not disciplined)

“I was told by my mother that I will be ready to be in a relationship when I’m 30 years and therefore anything that involves sex or relationships I cannot tell them” Respondent 6

R4: I tell my big brother and small sister at home about everything we learn and they think it is fine but I’m scared to tell my mother she might get annoyed with me for saying some things.” Respondent 4

Despite evidence that reproductive health education is beneficial to young people, parents have not always been supportive about their children learning and interacting with such kind of education. This is because of the many stereotypes and misconceptions surrounding reproductive health education especially if given to teenagers. Majority of parents however support abstinence only syllabi (Marla E. Eisenberg 2007) as it’s seen to be more favorable to the health of adolescents. This is similar to findings from this study as both teachers and students shared that parents are not always supportive of the reproductive health education that they receive in the health clubs.

4.6 Relevance and contribution

Majority of the students (94%) agree that they find their involvement in the health club meaningful and 91% of them also agree that the information they get would be important to their fellow students as well.

Table 4.7: Relevance and Contribution of Health Clubs to the Students

Importance of Health Club	Frequency	Percent
Yes	34	94.4
No	2	5.6
Total	36	100.0

The fact that other students find this information important as well is further confirmed through the FGD’s with the young people. All of the respondents shared that they find it easy to discuss this kind of information with their fellow students, their friends at home

and their siblings. From one of the schools the students in the health club are trained to be peer counsellors and therefore they are able to speak to their fellow students in the dormitories, in their classes and from other schools during school functions on the teenage pregnancies, menstruation, peer pressure, unsafe and early sex, STI's amongst other issues. The students mentioned that they get a lot of questions from their peers mostly regarding STI's, safe sexual practices, romantic relationships etc.

Q: How is the reaction to the topics you cover by the rest of the students, teachers and parents?

“Most of the other students in the dorms come to ask us questions about what we have learnt because they feel embarrassed to go ask other teachers or their parents at home.” Respondent 1

“My friend asked me if going to bash and socialising with girls is wrong, nikamwambia kusocialise si vibaya lakini hafai kujiweka in a position yenye atafanya vibaya” Respondent 6

(My friend asked me if going to bash and socialising with girls is wrong and I told them that socialising is not bad but they shouldn't put themselves in compromising situations)

“Wasee class huniuliza sana ju ya kujiprotect na safe sex lakini me huwaadvise waabstain” Respondent 1

(My peers in class ask me about safe sex and I advise them to abstain)

“My friend was itching and she told me about it and I helped her go to a Youth Friendly Centre close to my school where she got treated. She was told she had a yeast infection and our teacher had taught us about it.” Respondent 2

“My friends at home are always asking me what I learn in our health club and they ask me a lot of questions some of which I can't answer and I ask our teacher to help.” Respondent 3

One of the teachers said that there has been a lot of interest shown by the rest of the students in the schools on the topics discussed in the health club they plan to expand and ensure there's good representation of students from all the class levels.

Some of the students in one of the schools which was part of the study shared that culture is a major challenge in practicing what they are taught in the club. This is because most of them are required to marry before they are 18 years and by that age they usually have not completed their secondary school education. They are not expected to move out of their parents' house but they have wives brought to them by relatives to start living with them. Some have tried to stand their ground and speak their rights as they are taught in the health clubs but it's frowned upon and considered very disrespectful to refuse the wishes of their parents or elders. Therefore, most of them stay married from a very early age with equally young brides. By the end of their first year in marriage they are already teenage parents. And while they do not drop out of school because of that it does affect their overall well-being as they have to take up more responsibilities from a very early age. The patron of the health club from which the students face this challenge informed the researcher that, some of the students have been lucky and haven't gotten married while still in school but most of their peers have families at home and they keep it a secret for fear of ridicule by other students who are not from their community.

According to the official at the ministry of education, culture has been one of the biggest hindrance in access to education for many learners and especially RH education which is mostly frowned upon by parents. Cases of Female Genital Mutilation and early marriages contribute greatly to the rising number of teenage pregnancies in the country. Mainly because once a learner goes through FGM or gets married, culture expects them to already start child bearing and this mostly leads to dropping out of schools

One of the patrons for the school health clubs stressed that there's very limited parental guidance to the young students when it comes to reproductive health matters. Young children have access to a lot of content from the internet, television shows and social media where they access very inaccurate information reinforcing myths and misconceptions around their health and changes they experience. Unfortunately they lack guidance both at

home and in school since no one is open enough with them to give them correct and accurate information and limit the content they access. The teacher gave a story about a young girl in his school who had an STI but could not tell anyone at home, in school she approached the teacher but asked her not to report to her parents because she will get in trouble. The school was able to cover her hospital costs and the teacher respected the wishes of the girl however she has kept guiding her and giving her more information about her reproductive health.

To address the cultural hindrances to learners in accessing RH information and services, the RH coordinator of Nairobi County shared:

“As a county we have set up an advisory wing which consists of young people aged 18-24 years who give us insights on how we can help reach to their peers and those close to their age in addressing RH challenges. Some of the strategies we use include; holding community dialogues with parents to educate them on the poor health outcomes that young people face and how they can support them to take care of themselves. We also hold outreaches together with youth friendly clinics and peer educators during school holidays to pass and create awareness on RH to the young learners.”

RH Coordinator Nairobi County

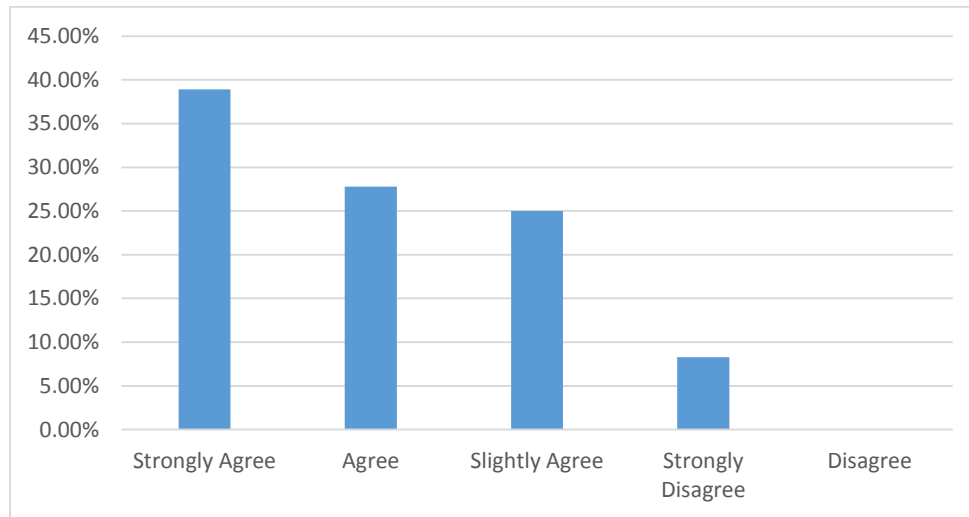
Because of such challenges the teacher feels the life skills education curriculum should be able to accommodate more topics that are currently affecting young people in the society.

‘If we don’t give correct information to them, they will find it elsewhere and it might be wrong, we instead need to build their capacity to address these issues’ Teacher, Nairobi Milimani High School

According to the patrons of the health club, they have seen changes in behaviour among the students in the club through their interaction with the RH information and education. In one of the schools which is a mixed day school, they have had 0 reported cases of teenage pregnancies for the past 2 years. This is since the club started being effective in the school. They attribute this to the rules they have as a school and the open culture they have with their students in discussing RH matters.

Most of the students (52.8%) strongly agree that the information they receive in the health club has helped them make better decisions about their sexual health as illustrated by figure 4.4.

Figure 4.4: Decision Making



All of the students agree that being part of the health club has provided them with new information about their reproductive health. In the FGD's the students mentioned that they used to have a lot of myths and misconceptions about different topics. The learners also agreed that the information they have received has provided them with new knowledge on unintended/teenage pregnancies and in the FGD's they admitted to further having more misconceptions about the subject. Some of the myths on teenage pregnancies they used to have are as follows; a girl cannot get pregnant if she has sex standing up, a young boy at 10-13 years cannot get a girl pregnant, a relationship without money and sex is not a healthy, contraceptives when used by young girls below 20 years causes infertility and should only be used by women who have already given birth and early pregnancy is the fault of the girl as boys do not get pregnant

The students mentioned that through their engagement this myths and misconceptions have been clarified and they know better. Table 4.8 illustrates the extent to which young people agree that the information they receive provides them with more knowledge about teenage pregnancies.

Table 4.8: New Knowledge on Unintended Pregnancy

Knowledge on RH	Frequency	Percent
	2	5.6
Strongly Agree	20	55.6
Agree	11	30.6
Slightly agree	3	8.3
Total	36	100.0

Almost half of the students (41.7%) strongly agree that teenage pregnancy is the responsibility of both the boys and girls. However during the FGD’s the boys who participated in the session had different views about this. As shown by the excerpt from the FGD, some agreed that it was both the responsibility of boys and girls while others felt it was more of a girl’s responsibility.

Q: Who is more responsible when it comes to early unintended pregnancy?

“It’s the girls fault, yeye ndio anajielewa na anafaa kukataa maboi kumtumia” Respondent 1

(It’s the girl’s fault she knows herself better and should say no to boys who want to use her)

“Ata maboy wako na responsibility kubwa, both of you should be able to use protection and prevent this” Respondent 2

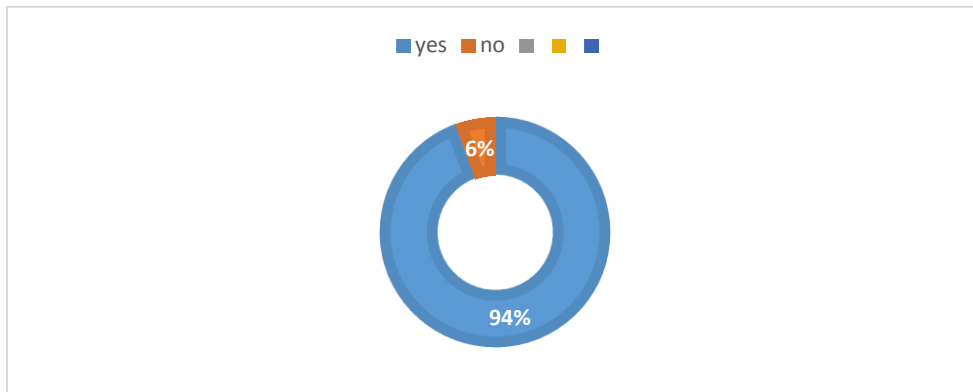
(Even boys have a huge responsibility, both should be able to use protection to prevent this)

“Maboy wengine ata huforce madem it’s more of a man’s responsibility to prevent pregnancy but dem akishapata ball responsibility inakua ya wote” Respondent 4

(Some boys force girls, it’s more of a man’s responsibility to prevent pregnancy however once a girl gets pregnant all responsibility falls on her).

There were also varying responses when the researcher asked the students if a girl can return to school after they have given birth. As shown in table 4.5, 35% of the students strongly agree that the girls can return to school after birth while only 6% disagree with this.

Figure 4.5: Return to School by Teenage Mothers



In the FGD's some of the students felt that after a girl has given birth they should take between 1-2 years to take care of the child before they return to school. From their personal experiences as well they said that most of the girls they have seen in their communities who give birth they never go back to school and sometimes they get married by the father of the child if he is older and continue having more children.

The official from the ministry of education informed the researcher that the return to school guidelines are clear that any learners who drops out of school for any reason should be allowed to go back to school. Therefore even teenage mothers should go back to school after six months of giving birth or whenever they are ready. She however mentions that it is unfortunate that this does not happen as stipulated by the guidelines since teachers have not read and understood the guidelines and parents are not aware of it completely. The officer also sighted that some schools may not be willing to accept students after they give birth because it portrays their school badly as one where students have no morals and they get pregnant instead of having good grades. Such schools send away their students immediately their pregnancy is known to the teachers.

The teachers who were part of the study as key informants blamed parents for the cases of school dropouts after giving birth by teenage mothers. This is because parents transfer them to different schools where no one knows them to start “afresh” or take them to rural areas to live with their grandparents as they bring up their children. The teachers have also observed that girls who do not return to school after giving birth are more likely to have more children while they are still teenagers.

Lack of parental guidance on issues of sexuality and sex education inhibit access to relevant knowledge by adolescents that would enable them to make informed choices about their sexual health (Maureen Were, 2007). The blame between teachers and parents has for a long time been a topic of discussion. Whereas parents feel that teachers spend more time with the students and should therefore be able to guide them, teachers feel that it is the responsibility of parents to shape the characters of their children. According to this study, teachers felt that parents are not taking up their parental roles to the children and hence the reproductive health challenges being faced today. Proper guidance should be provided by both parents and teachers to adolescents especially since they are going through puberty which is a turbulent time for both boys and girls (Anne Waithaka; AFIDEP 2019). It should however be noted that sometimes parents are not able to offer reproductive health guidance to their children because of cultural barriers and knowledge gaps about some issues which may sometimes lead to misinformation. The contribution of reproductive health information and education in the lives of adolescents would be more effective if both teachers and parents put the same effort to educate them and guide them on their sexual health.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Overview

This chapter features a summary of key findings of the study in addition to presenting conclusions on the basis of the study findings. It also outlines a number of recommendations to be considered in order to effectively use reproductive Health Information and Education to change the behaviours of young learners in addressing teenage pregnancies and other RH challenges they face.

5.2 Summary of Findings

This study primarily set out to establish the place of Behaviour Change Communication in addressing teenage pregnancies in secondary schools in Nairobi County through the use of reproductive health information and education. The first objective was to explore the delivery of reproductive health information and education in secondary schools in Nairobi County.

This study found that majority of teachers have to integrate the life skills education curriculum with other sexuality education curriculums from civil society organisations focused on education. This is mainly because they find the Life Skills education curriculum lacking in many aspects of RH and do not address issues comprehensively. Questions raised by learners on reproductive health are not included in the curriculum and therefore teachers are forced to find more content elsewhere. From this study all the teachers confirmed that they have collaborated with external partners to provide RH information and education to their learners. This finding is similar to a report published by UNESCO and UNFPA in 2011 which found that the curriculum includes information that is generally of good quality and deals with behaviours related to sexual health outcomes such as avoiding premarital sex, preventing sexual coercion, not perpetuating harmful traditional practices, responding assertively to harassment, abuse, bullying and peer pressure (UNESCO, UNFPA, 2011).

However, the curriculum registers gaps whereby information on contraceptives, condoms, sex and sexual health were only superficially addressed and excluded topics as reproduction, STI's and access to sexual health services and sexual diversity

The study also showed that culture and religious beliefs of the teachers can form bias in delivery of certain topics. For example, in this study, a number of the students quoted Bible verses that their teachers had shared with them to help them understand the context of their lessons. Similarly, some of the teachers admitted to having difficulty in addressing some of the topics because of their cultures and traditions. This also created difficulty when it came to answering questions posed by students on the topics they felt uncomfortable to address. Some of these topics include; sexual diversity, sex, safe abortion, gender norms in relationships etc. Further in-depth analysis showed these findings resonate with the 2017 findings by the Guttmacher Institute on Sexuality Education in Kenya where it was found that 45% of teachers felt unprepared or uncomfortable answering students' questions; and six in 10 teachers strongly emphasised that sex is dangerous and immoral. There need to be avenues to include a reconciliation between faith and religious values and RH education. Therefore, the curriculum should prepare teachers to be better equipped to deal with moral dilemmas and get a better understanding of misconceptions located in religious and cultural beliefs versus facts.

From the study it was clear that young learners thoroughly enjoy delivery methods that are not routine as in their regular classes. They enjoy having group discussions of which 54% of the learners said they receive information through and making use of their talents and abilities to illustrate what they have learnt to their peers and demonstrate their understanding of the topics they cover. When learners get RH information in such vibrant ways they get interested more and have their schoolmates also curious about what they are learning.

This study shows contribution of reproductive health information and education in the life of the students. The study showed that the engagement of the students in the health club has helped them become more responsible and disciplined in school. The learners report to being more aware of RH issues and they no longer believe in the myths and misconceptions

they have known and held on to for a long time. The study found out that the RH information and education they receive in the health clubs have provided them with new knowledge on RH issues such as teenage pregnancies, early sexual debut, drugs and substance abuse, STI's amongst others. Almost half of the students (39%) agreed strongly that the information they have received has helped them make better decisions about their sexuality. Literature review as well showed that adolescents and young people who have received sexuality education are able to make more accurate and informed decisions about their reproductive health.

This study also found that young learners are able to share the information they receive with their peers and they can advise them on issues they would otherwise not consider talking about. The respondents showed confidence and the ability to speak out easily on RH matters which is not the case among their peers who have not interacted with RH information and education. The students as well reported to being able to avoid peer pressure and getting themselves in compromising situations through their engagement in the club. Some of their peers think they are foolish for not participating in common practices such as going for end of term and end of year bash, not having sex and not drinking alcohol or other substances they use. They are considered as stiff for not taking part in "fun" activities that their peers do but they are usually the first point of contact when their friends need information on RH. According to a study by Dana Rotz in July, 2018 Peer led Approach led to improvement in exposure to information on sexual health topics and knowledge of preventing pregnancy and transmission of sexually transmitted infections. These findings are quite similar to this study as the students who are part of the health clubs have been able to reach more of their peers with RH information and education thus increasing their access and awareness with knowledge and information

The third and final objective was to find out the issues affecting uptake and utilisation of reproductive health information and education in secondary schools in Nairobi County. Through discussions with the students, the study found out that the students receive minimal support from their parents and guardians towards their involvement in the health club. More than half of the students (69%) report to getting approval from their parents to participate in the health club but only because they do not tell them the exact topics of what

they cover in the club. This can be attributed to cultural and religious beliefs which do not allow for issues such as sex to be discussed openly and especially to children. In addition to this, the young learners are also not comfortable speaking about any reproductive health issues with their parents and guardians mainly because such topics are not usually discussed with them. The study found out that students are more willing to share issues affecting their reproductive health with their friends, friendly teachers and sometimes their siblings. Usually their parents or guardians are the last option. The study also shows that some parents are not comfortable when their children are taught RH issues by teachers who are not from the same religion as theirs. They would prefer that their children get this kind of information from teachers who share their religion and their culture as well.

Aside from school the respondents mentioned that they own phones at home and they search health issues which they have little no information on. Usually, the students are eager to share what they learn with their peers regardless of where they get this information from. Despite young people's access to the internet, many of them do not have the skills to distinguish reliable sources of information from unreliable ones. This is a skill that the life skills education syllabus should be providing too

While many learners gave the impression of feeling positive about most of the topics they tackled in their health clubs, they seemed to still struggle with gender norms surrounding certain topics that they covered such as relationships and responsibility when it came to unintended pregnancies. The understanding of what constitutes a healthy relationship by the learners was mixed. Some learners were able to explain issues like consent, absence of violence, communication, trust, and mutual respect, as being key to healthy relationships. Other learners mentioned some gender stereotypes within relationships as being healthy such as: A healthy relationship is where a girl utilises resources that the boy has and the boy has control over the girl's moods. On teenage pregnancies, the respondents had arguments amongst themselves on whose responsibility it was when a girl wound up pregnant. Most of the respondents especially the ladies felt that it was both the responsibility of both the boy and girl however some of the boys felt that it was the responsibility of the girl to say no to sex while she is in still in school and to ensure that if they do have sex it should be protected.

The study also found out that teachers are more receptive to students when they share their RH challenges with them. They are supportive and they give them guidance through the health clubs and the available curriculums. However, the teachers also have religions and cultures that play a role in the delivery and understanding of topics they consider “sensitive”. Such topics include masturbation, abortion, sexual diversity, sex etc. With integration of the life-skills education with other curricula, these topics are well covered but it is dependent on the facilitator’s own level of comfort and values whether or not to have honest and comprehensive discussions on the topics. Therefore there is minimal discussion on aspects of sexuality and sexual health and a lot of emphasis on abstinence, drug use, avoiding peer pressure, and the dangers of engaging in sex while still in school. However, from engagement with the learners, they still had a lot of curiosity about relationships, sex and sexual diversity.

From the theories underpinning this study; health belief model, we understand the critical role a person’s understanding of the benefits of adopting a new behaviour has in their decision to adopt and sustain that behaviour. In this case a student’s understanding of the benefits of preventing themselves from unintended pregnancies or other sexually transmitted infections will influence their decision to change their behaviour and sustain a healthy lifestyle. Additionally, from the theory of social change, the role of interactions among the students in the health club and the ability to influence how they perceive a certain behaviour has a bearing on how they decide to utilise the RH information and education they receive.

5.3 Conclusion

Despite a very limiting socio-cultural context that significantly contributes to the curtailing of discussions on reproductive health to young people, especially those in-school, it is possible to adopt a positive approach in discussions and sharing of knowledge on reproductive health in any environment that these learners exist in. Reproductive health knowledge that the learners receive not only helps them to make sound decisions on their sexuality but has been shown by this study to contribute to their discipline and sense of responsibility.

The study has shown that learners want more reliable information on sexual health and relationships. As was shown in the data and analysis section, they have a lot of questions and misconceptions on matters related to sexuality and Sexual Reproductive Health and Rights. With their access to the internet and mobile phones, they have a lot of avenues to get information but not the skills to discern whether it is reliable information or not. Without receiving RH education that is comprehensive, honest and open about sexuality, they are more likely to have difficulty towards their overall sexual health and wellbeing. This is especially so for girls and young women since gender norms around sexuality and sexual relationships are not being questioned and are yet to be transformed. There is a disconnect among some of the students on the information they have received, their understanding of the information and their actions on certain issues such as teenage pregnancies which if not addressed a lot of the blame and burden of being a teen parent will continue to rest on the girls.

The life-skills education curriculum is not comprehensive and does not address many of the RH issues that young learners go through. It is lacking in different components and does not give the teachers much content to work with. Because Life Skills education as a subject is not examinable and has no set targets by the MoE the teachers do not give it much importance. They would rather complete other subjects as per the set targets rather than taking the time to teach this lesson. The MoE should consider evaluating the curriculum against the different RH challenges that Kenya has been experiencing recently among young learners and realistically include and address this issues.

5.4 Recommendations

This study proposes four key recommendations influenced by the realities of the barriers which continue to limit the uptake and utilisation of Reproductive Health Information and education by young students. The recommendations are aligned with the study objectives to improve the uptake and use of RH information and education by secondary school going students in the efforts towards addressing teenage pregnancies in Kenya.

5.4.1 Include Reproductive Health education in the Kenyan School Curriculum

The study recommends that through the Kenyan MoE, the school curriculum should be inclusive of RH education without overlooking any of the issues that are affecting young students in schools. The information should be gradual and appropriate for the student's age and class level. The Ministry of Health and the Ministry of Education has been working in silos in their strategies towards addressing teen pregnancies and other RH challenges, they should integrate their efforts and work together for maximum impact. The study has shown limited to no awareness of policies, guidelines and curriculums that are meant to protect and guide students in their lives by parents, some teachers and even the learners themselves. Therefore it would be important that the MoE includes the students in development of a comprehensive RH education curriculum to avoid any assumptions of what the students would want to learn, hold dissemination workshops for teachers for any guidelines, policies or curriculums developed for them and the students and the schools to organic step down trainings or disseminations of these curriculums, policies and guideline to parents for their awareness, understanding and approval. The MoE should as well ensure that every school has a professional guidance and counselling teacher who is ethical and can guide the students whenever they may have challenges while keeping information confidential.

5.4.2 Involve Students in Delivery of RH Education

This study has shown that students discuss what they learn with their fellow students and friends thus widening the reach of young learners both in and out of schools with reproductive health information. This registers as a best practice which can be adopted by more schools to ensure that learners are fully equipped with the right information on reproductive health. Some of the schools reported to having guest speakers and peer educators from external sources who have talks and discussions with students on RH issues. However, the Ministry of Education has in the recent past banned activities in schools offered by any external sources. Therefore training students as peer educators and peer counsellors will bridge the gap created by not having external individuals interact with the students by having their schoolmates deliver RH information to them. The students are more relatable to their peers thus may improve understanding of the information they provide to them.

5.4.3 Address Parental Concerns and Resistance to RH Education

This study has shown that parents are not always very receptive to their children receiving RH education mostly because of cultural and religious biases and that such issues are only expected to be discussed with other adults. The perception is, giving information about RH to adolescents would make them more curious and they would want to try what they have learnt and that this kind of information breeds bad behaviour among the students. This are legitimate concerns and worries from parents which should be addressed. Some of the ways that this could be done is adopting a whole school approach in delivery of RH education. Meaning, the teachers not only involves the students in delivery of this information as it is in the schools the study interacted with, but ensures the whole school is aware of the kind of information they are receiving and how they can support. This should include; parents, the school board, head of the schools, other teachers and the supporting staff in the school. This would provide a safe environment for the students to speak out on their issues with anyone at home or in school without fear of judgment or ridicule.

5.4.4 Recommendations for Further Research

This study recommends that further scientific inquiries should be done to evaluate the impact of RH education in changing the behaviours of young learners in secondary schools towards addressing teenage pregnancy at national level. Further scientific inquiries are needed to determine the sustainability of the healthy behaviours that the young learners adopt after their interaction with RH education and information.

REFERENCES

- Abubakar, A., Van de Vijver, F. J., Fischer, R., Hassan, A. S., Gona, J. K., Dzombo, J. T., & Newton, C. R. (2016). 'Everyone has a secret they keep close to their hearts': challenges faced by adolescents living with HIV infection at the Kenyan coast. *BMC public health*, *16*(1), 197.
- Ahumuza, S. E., Matovu, J. K., Ddamulira, J. B., & Muhanguzi, F. K. (2014). Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda. *Reproductive health*, *11*(1), 59.
- Al-Haddabi, R., Al-Bash, M., Al-Mabaihsi, N., Al-Maqbali, N., Al-Dhughaiishi, T., & Abu-Heija, A. (2014). Obstetric and perinatal outcomes of teenage pregnant women attending a tertiary teaching hospital in Oman. *Oman medical journal*, *29*(6), 399.
- Altinyelken, H. K., & Olthoff, J. (2014). Education and sexual and reproductive health and rights: a review of the critical debates. The Amsterdam Institute for Social Science Research (AISSR). Amsterdam: *University of Amsterdam*.
- Asheer, S., Berger, A., Meckstroth, A., Kisker, E., & Keating, B. (2014). Engaging pregnant and parenting teens: Early challenges and lessons learned from the evaluation of adolescent pregnancy prevention approaches. *Journal of Adolescent Health*, *54*(3), S84-S91.
- Beguy. (2014, July 16). Unintended pregnancies among young women living in urban slums: evidence from a prospective study in Nairobi city, Kenya. *PUBMED*
- Bissell, M. (2016). Socio-economic outcomes of teen pregnancy and parenthood: A review of the literature. *The Canadian Journal of Human Sexuality*, *9*(3), 191.
- Cape, U. O. (2014). Qualitative data analysis. *Western Cape*.
- Caroline Ronsmans, W. G. (2006). Maternal Mortality: who, when, where and why. *The lancet* *368* (9542), 1189-1200.

- Cassell, C., Santelli, J., Gilbert, B. C., Dalmat, M., Mezoff, J., & Schauer, M. (2015). Mobilising communities: an overview of the Community Coalition Partnership Programs for the Prevention of Teen Pregnancy. *Journal of Adolescent Health, 37(3), S3-S10*Mezey, G., Robinson, F., Gillard, S.
- Chandra, P. C., Schiavello, H. J., Ravi, B., Weinstein, A. G., & Hook, F. B. (2015). Pregnancy outcomes in urban teenagers. *International Journal of Gynecology & Obstetrics, 79(2), 117-122.*
- Chapter 17: Maternal Reproductive and Child Health. (2017). In D. P. Lawrence Gostin, Advancing the right to health: the vital role of law.
- Chau, K., Traoré Seck, A., Chandra-Mouli, V., & Svanemyr, J. (2016). Scaling up sexuality education in Senegal: integrating family life education into the national curriculum. *Sex Education, 16(5), 503-519*
- Christina L. Jones, J. J. (2014). The Health Belief Model as an Explanatory Framework in Communication Research: Exploring Parallel, Serial, and Moderated Mediation. *Health Communication, 567-575.*
- Cohen. (2000). Research Methods in education.
- Creswel, J. W. (2009). Research design Qualitative, Quantitative and mixed methods approaches. *SAGE Applications.*
- Creswell, J. W. (2014). Research Design Qualitative, Quantitative and Mixed Methods Approaches Second Edition. London: *International Educational and Professional Publisher.*
- Dickens, B. (2018). The challenges of reproductive and sexual rights.
- Draft Maputo Plan of Action 2016-2030.
- Donald Cooper, P. S. (2011). Business Research Methods. *McGraw-Hill/Irwin.*

- Elard Koch, J. T. (2007). Women's education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007. *PLoS one*.
- Elo, I. (1992). Utilisation of Maternal Health-care services in Peru: The role of Women's Education. *Health Transition Review*, 49-69.
- Glasier, A., Gülmezoglu, A. M., Schmid, G. P., Moreno, C. G., & Van Look, P. F. (2016). Sexual and reproductive health: a matter of life and death. *The Lancet*, 368(9547), 1595-1607.
- Guttmacher Institute, Adding it Up: Investing in Contraception and Maternal and Newborn health, 2017, factsheet, New York: *Guttmacher Institute 2017*.
- Harrington, A. (2005). *Modern Social Theory*. Oxford University Press.
- Health, K. B. (2014). Kenya Demographic and health survey. *Ministry of health*.
- Holthausen, J. (2013). Scientific review of the Social Exchange Theory and its contribution to solving purchasers' decision making issues (MA Thesis). *University of Twente, the Netherland*
- Hughes, J., & McCauley, A. P. (1998). Improving the fit: adolescents' needs and future programs for sexual and reproductive health in developing countries. *Studies in family planning*, 233-245.
- IPPF. (2013). Demystifying data; A guide to using evidence to improve young people's sexual and reproductive rights in Kenya.
- Irwin Rosenstock, V. S. (1988, June). Social Learning Theory and Health Belief Model. *Health Education Quarterly*, pp. 175-183.
- Johnson, C. D., Jones, S., & Paranjothy, S. (2016). Reducing low birth weight: prioritising action to address modifiable risk factors. *Journal of Public Health*, 39(1), 122-131.

- Joseph Mumba Zulu, Astrid Blystad (2019). Why teach sexuality education in school? *Teacher discretion in implementing comprehensive sexuality education in rural Zambia*.
- Kalembo, F. W., Zgambo, M., & Yukai, D. (2013). Effective adolescent sexual and reproductive health education programs in sub-Saharan Africa. *Calif J Health Promot, 11(2), 32-42*.
- Kegler, M. C., Williams, C. W., Cassell, C. M., Santelli, J., Kegler, S. R., Montgomery, S. B & Will, J. A. (2015). Mobilising communities for teen pregnancy prevention: Associations between coalition characteristics and perceived accomplishments. *Journal of Adolescent Health, 37(3), S31-S41*.
- KNBS. (2009). Kenya National Population Census Survey. *Kenya National Bureau of Statistics*
- Klaiman, T., Chainani, A., & Bekemeier, B. (2016). The importance of partnerships in local health department practice among communities with exceptional maternal and child health outcomes. *Journal of Public Health Management and Practice, 22(6), 542-549*.
- Lamorte, W. W. (2016, April 28). The Health Belief Model. Retrieved from Behavioral Change
Models: sphweb.bumc.bu.edu/otlt/MPHModules/SB/BehavioralChangeTheories/BehavioralChangeTheories2.html
- Macdonald, D. I. (2017). An approach to the problem of teenage pregnancy. *Public Health Reports, 102(4), 377*.
- Mantovani, N., Meyer, D., White, S., & Bonell, C. (2017). Tackling the problem of teenage pregnancy in looked-after children: *a peer mentoring approach*. *Child & Family Social Work, 22(1), 527-536*.

- Marcell, A. V., & Burstein, G. R. (2017). Sexual and reproductive health care services in the pediatric setting. *Pediatrics, 140*(5), e20172858.
- MOH. (2014). Kenya Demographic Health Survey (KDHS). *MOH/KNBS*.
- MOH (2016). National guidelines for provision of Adolescent-Youth Friendly services. *MOH*
- Mason-Jones, A. J., Crisp, C., Momberg, M., Koech, J., De Koker, P., & Mathews, C. (2012). A systematic review of the role of school-based healthcare in adolescent sexual, reproductive, and mental health. *Systematic reviews, 1*(1), 49.
- Moletsane, R., & Brookings Institution (Washington, DC). (2014). The need for quality sexual and reproductive health education to address barriers to girls' educational outcomes in South Africa. *Center for Universal Education*.
- Mugenda. (2003). Research Methodology sample for local researchers.
- Mugenda, O. M. (2003). Research Methods: Qualitative and Quantitative Approaches. *Nairobi Acts Press*.
- Mumah, J., Kabiru, C. W., Izugbara, C., & Mukiira, C. A. R. O. L. (2014). Coping with unintended pregnancies: Narratives from adolescents in Nairobi's slums. Nairobi, Kenya: *African Population and Health Research Center*.
- Mutuli, R. U. T. H. (2014). Challenges Affecting the Implementation of Strategic Reproductive Health Programmes among Level Five Hospitals in Nairobi, Kenya.
- Ngo, A. D., Alden, D. L., Hang, N., & Dinh, N. (2015). Developing and launching the government social franchise model of reproductive health care service delivery in Vietnam. *Social Marketing Quarterly, 15*(1), 71-89.

- Robling, M., Bekkers, M. J., Bell, K., Butler, C. C., Cannings-John, R., Channon, S & Kenkre, J. (2016). Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial. *The Lancet*, 387(10014), 146-155.
- Rutgers (2018). Culture, Religion and Sexual and Reproductive Health and Rights. *Rutgers*
- Ssewanyana, D., Mwangala, P. N., Marsh, V., Jao, I., van Baar, A., Newton, C. R., & Abubakar, A. (2018). Challenges and Young people's and stakeholders' perspectives of adolescent sexual risk behaviour in Kilifi County, Kenya: a qualitative study. *Journal of health psychology*, 23(2), 188-205.
- Tork, H. M. M. (2015). Effects of reproductive health education on knowledge and attitudes among female adolescents in Saudi Arabia. *Journal of Nursing Research*, 23(3), 236-242.
- Unpublished data from Sindh S, Darroch JE and Ashford LS, Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014
- Vickie Lambert, C. L. (2012). Qualitative Descriptive Research: An Acceptable design. *Pacific Rim International Journal of Nursing Research*, 255-256.
- Visaria, L., Jejeebhoy, S., & Merrick, T. (2018). From family planning to reproductive health: challenges facing India. *International family planning perspectives*, S44-S49.

APPENDICES

Appendix 1: Consent Form

PARTICIPANT INFORMATION AND CONSENT FORM

(To be administered in English or any other appropriate language e.g. Kiswahili translation)

Title of Study: Behaviour change communication and teenage pregnancies in secondary schools: A study of Nairobi County

Principal Investigator: Amina Judy Nyamvula - University of Nairobi

Introduction: I would like to tell you about a study being conducted by the above listed researcher. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be a participant in the study. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions to your satisfaction, you may decide to be in the study or not. Once you understand and agree to be in the study, I will request you to sign your name on this form. Your decision to participate is entirely voluntary, you may withdraw from the study at any time without necessarily giving a reason for your withdrawal and refusal to participate in the research will not affect your education, your participation in your health club or interactions with other students. We will give you a copy of this form for your records.

May I continue? YES / NO

What is this study about?

The purpose of the interview is to find out the reproductive health issues specifically on teenage pregnancies among Secondary school going students in Nairobi County.

Participants in this research study will be asked questions about their interaction with reproductive health education and information in their school health clubs.

There will be approximately 60 participants in this study randomly chosen. I am asking for your consent to consider participating in this study.

What will happen if you decide to be in this research study?

If you agree to participate in this study, the following things will happen: You will be interviewed in a private area either alone or with a small group of your peers where you feel comfortable answering questions. The interview or focus group discussion will last approximately 45 minutes. The interview will cover topics such as reproductive health information in health clubs, interaction with your peers on reproductive health issues, teenage pregnancy etc.

I will ask for a telephone number where we can contact you if necessary. If you agree to provide your contact information or that of your parent/teacher/guardian, it will be used only by people working for this study and will never be shared with others. The reasons why I may need to contact you are just for follow up in case of clarification need.

Are there any risks, harms discomforts associated with this study?

One potential risk of being in the study is loss of privacy. I will keep everything you tell me as confidential as possible. I will use a code number to identify you in a password-protected computer database and will keep all of the paper records in a locked file cabinet. However, no system of protecting your confidentiality can be absolutely secure, so it is still possible that someone could find out you were in this study and could find out information about you. Also, answering questions in the focus group discussion or interview may be uncomfortable for you. If there are any questions you do not want to answer, you can skip them. You have the right to refuse to answer to any questions asked during the interviews and FGD's.

Are there any benefits being in this study?

You may benefit by receiving free health information on your reproductive health. The principle investigator will refer you to a youth friendly center for care and support where necessary.

Will being in this study cost you anything?

There will be no cost involved by being in this study

What if you have questions in future?

If you have further questions or concerns about participating in this study, please call or send a text message to the number provided at the bottom of this page.

What are your other choices?

Your decision to participate in research is voluntary. You are free to decline participation in the study and you can withdraw from the study at any time without injustice or loss of any benefits.

Participant's statement

CONSENT FORM (STATEMENT OF CONSENT)

I have read this consent form and had the information read to me. I have had the chance to discuss this research study with the study investigator. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study. I understand that all efforts will be made to keep information regarding my personal identity confidential.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study: **Yes** **No**

I agree to provide contact information for follow-up: **Yes** **No**

Date:

	Participant Name	School	Contact	Signature

Parent Guardian Consent Form (statement of consent)

If the research participant is under the age of 18 years the consent form should be signed by a parent or legal guardian

Research Participant Name _____

Parent/Guardian statement

I am the father, mother or duly appointed guardian of the above-named Applicant with full parental rights and authority, and I have read and understood the purpose and relevant details of the research study to which upon my child agreeing to be part of the focus group discussions and interviews has agreed to be part of the study. By signing this consent form, I hereby agree to my child being part of the study and will ensure that my child will honor his/her obligations

I agree to my child's participation in this research study: **Yes** **No**

I agree to provide contact information for follow-up: **Yes** **No**

Guardians printed name: _____

Guardian's signature / Thumb stamp _____ **Date** _____

Parent or Legal Guardian Information:

Phone _____ **Email** _____

Address _____

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given his/her consent.

Researcher's Name: _____ **Date:**

Signature

Role in the study: _____ *[i.e. study investigator who explained informed consent form.]* For more information contact _____ at _____

Witness Printed Name *(If witness is necessary, A witness is a person mutually acceptable to both the researcher and participant)*

Name _____ **Contact information** _____

Signature /Thumb stamp: _____ **Date;** _____

Appendix 2: FGD Guide

INTRODUCTION:

My name is Judy Amina and I am collecting information seeking to understand the reproductive health issues specifically on teenage pregnancies among Secondary school going students in Nairobi County. Participants in this research study will be asked questions about their interaction with reproductive health education and information in their school health clubs.

Your names will not be linked to the information you give however for purposes of recording all your responses we shall use coded identification. We will endeavor to maintain confidentiality for all our responses.

Please note that your participation is voluntary but we will however appreciate your responses and contributions. You are free to stop responding to the questions at any point and will not be penalised for your decision to do so.

We will also be seeking your contacts in order to follow up with further questions and information should there be need. We will keep your contact information confidential and will ensure it is not linked to the information you give us.

If you are willing to participate in the study please sign a consent form (To be provided separately) **If you have questions or concerns**, please contact the lead researcher (contact information is provided on the informed consent form attached).

Questions for the discussions

1. Introduction of name by the participants.
2. What is your role in your school health club?
 - *Describe main activities and tasks in the club*
3. How did you get involved in the club?

- *Probe for own motivation, selection procedure, degree of choice for participation*

4. How is it going?

- *What do you like about your involvement in the club?*

- *What is challenging?*

5. What kind of topics have you been able to tackle in your club?

- *Mention topics and how long they take per topic*

6. Do you feel your activities and are important in addressing teenage pregnancies in your school?

-*Why/how? Can you give examples?*

-*Probe for results (get stories about how individuals were helped, rather than just mentioning areas like “they now have knowledge”)*

(See if you can pinpoint exactly what it was that the club has done, that has helped in addressing teenage pregnancies in their school e.g.; discussed about issue and gave advice)

7. Which topics do you find are most difficult to tackle in your health club and Why?

8. Do you do anything special in your club to try and reach the rest of the students with the information you learn especially on reproductive health? What?

9. In what way do you receive reproductive health information in your club? E.g. plays, poems, discussions, quiz etc.

-*Which mode do you enjoy the most and why? Which mode do you least enjoy and why?*

10. How is the reaction to the topics you cover by the rest of the students, parents and teachers

- Are they against it? Are you perceived in a certain way or do they support you?

(get practical stories on how they receive support from their environment in the club and if the perception is negative get story on why it is viewed negatively)

11. How does your participation in the health club enable you to make accurate and well informed decisions about your reproductive health

- see if and how they understand the term empowered and find out in what ways especially in terms of their sexuality

12. How is the health club making any change in your school on the numbers of reported teenage pregnancies, early sexual debuts and other sexually transmitted infections?

13. What are some of the challenges that your health club and other students face in addressing reproductive health issues?

- Probe for the details,(mode of delivery, support, lack of information)

14. In your school and club how do you deal with these challenges?

15. What kind of support do the teacher, parents and guardians give you in your health club?

16. Probe for how they try to cope with these challenges and what kind of support they get from the school, parents and guardians and from each other. Do they articulate about these challenges to school? Do they look for solutions together with adults around them?

17. How has your health club prepared to deal with these reproductive health challenges? (Such as teenage pregnancies, peer pressure, early sexual debut, alcohol and drug abuse etc.)

Probe for how did they prepare you? Has the information received helped to make better decisions about their health

18. When you have guest speakers, do you find the information given by them important

Probe for impact by guest speakers and preference

19. What expectations did you have for the health club and are those met?

Appendix 3: Key Informant Interview Guide

INTRODUCTION:

My name is Judy Amina and I am collecting information seeking to understand the reproductive health issues specifically on teenage pregnancies among Secondary school going students in Nairobi County. Participants in this research study will be asked questions about their interaction with reproductive health education and information in their school health clubs.

Your names will not be linked to the information you give however for purposes of recording all your responses we shall use coded identification. I will endeavor to maintain confidentiality for all our responses.

Please note that your participation is voluntary but we will however appreciate your responses and contributions. You are free to stop responding to the questions at any point and will not be penalised for your decision to do so.

We will also be seeking your contacts in order to follow up with further questions and information should there be need. We will keep your contact information confidential and will ensure it is not linked to the information you give us.

Interview with teacher/patron of club and teacher responsible for health

Introduction explaining the process and objective of the interview as well as confidentiality protocols

1. Name and role of participant in school and or the health club
2. Number of years involved in the school and in the health club
3. What are the reproductive health challenges experienced by the students in the school and what could be the cause?
20. *Probe for practical stories of the challenges faced by the students*
4. Was it an initiative of the school or the government to have a school health club in school and what purpose was it expected to serve?
5. Did it serve the purpose? If yes how? If not why?

6. Is your school health club practical in addressing teenage pregnancy in your school and in your area?
21. *Probe to find out if there are changes caused by the health club*
7. Do the students present other challenges other than the ones you have prepared to address in the club?
8. What methods of delivery do you use in the club? And what informs your mode of delivery (ability to answer questions posed by students, topics covered? Which do you find most difficult to address and why)
9. Have you noticed any change since the inception of the health club in your school in regards to level of teenage pregnancies? And other reproductive health issues?
10. What are the challenges of having a school health club and addressing reproductive health challenges
11. What are you doing to address this challenges and are you getting any further support from the school and the parents or guardians

Interview with official from the Ministry of Education

Introduction explaining the process and objective of the interview as well as confidentiality protocols

1. Name and title of participant
2. As the ministry of education what are some of the key challenge that you have observed in your capacity that learners face in regards to reproductive health
3. What are some of the measures you have put in place to tackle the rising cases of teenage pregnancies
 - *Probe for the strengths of the measures they have put in place*
 - *Probe for the level of success the official feels the measures have been able to achieve*

4. Life skills education is meant to be part of the Kenya school curriculum, is it comprehensive enough to address the teenage pregnancies among secondary school going learners?

– Probe for the official’s opinion about the existing life kills education

5. Would you like to see the life skills programme implemented differently?

-Probe how if the answer is yes

-Probe for protocols put in place to ensure that life skills education is well covered and given attention by teachers and students

6. What other instruments and strategies have the ministry put in place to ensure that learners are getting accurate information on their sexuality

-Probe for interventions such as the school health clubs

-Also probe for interventions to address teenage pregnancies in secondary schools

7. What challenges do you face in addressing teenage pregnancies in schools and what are you doing about it

-Probe if there are any constitutional or policy barriers on this

-Probe for practical examples on how they are addressing the challenges

8. What support are you getting from the schools, parents and other civil society organisations in addressing teenage pregnancy in the country

-Probe for interventions supporting their efforts if any

Interview with official from the Nairobi County department of Adolescent health

Introduction explaining the process and objective of the interview as well as confidentiality protocols

1. Name and title of participant and duration served at the county government of Nairobi
2. What issues in your opinion contribute to the rising numbers of teenage pregnancies in Nairobi County?
-Probe for the resources lacking linked to rise of teenage pregnancies e.g. lack of YFS
3. What do you see as the greatest barrier in addressing teenage pregnancies in Nairobi
- Probe for practical barriers that the participant has interacted with
4. What is the department of adolescent health doing to address this health challenge in Nairobi
-Probe for interventions put up by the county for the past 5 years
5. What do you think about the quality of reproductive health education offered in the current school curriculum
-Probe to seek interviewee's opinion on whether the quality of reproductive health information is comprehensive
-Prove for recommendations
6. What strategies could the County take to tackle the poor reproductive health outcomes to school going adolescents and young people (focus on teenage pregnancies)
7. Are you getting any support from the National government in addressing teenage pregnancies in the county
-Probe for support in terms of resources such as the health budget, training teachers on delivery of reproductive health education, tracking and monitoring of delivery of reproductive health education in schools

Appendix 4: Questionnaire Guide

INTRODUCTION:

My name is Judy Amina and I am collecting information seeking to understand the reproductive health issues specifically on teenage pregnancies among Secondary school going students in Nairobi County. Participants in this research study will be asked questions about their interaction with reproductive health education and information in their school health clubs.

Your names will not be linked to the information you give however for purposes of recording all your responses we shall use coded identification. We will endeavor to maintain confidentiality for all our responses.

Please note that your participation is voluntary but we will however appreciate your responses and contributions. You are free to stop responding to the questions at any point and will not be penalised for your decision to do so.

This questionnaire has 19 brief questions which you will be able to easily respond to. Feel free to ask any questions at any time

We will also be seeking your contacts in order to follow up with further questions and information should there be need. We will keep your contact information confidential and will ensure it is not linked to the information you give us.

If you are willing to participate in the study please sign a consent form (To be provided separately) **If you have questions or concerns**, please contact the lead researcher (contact information is provided on the informed consent form attached).

Instructions

First, I am going to ask you questions about yourself and the questions about the health information you have received will follow. Please feel free to tick/circle where applicable.

SECTION A: Social –Demographic Characteristics & Engagement in Health Club

1. Gender

Male [] Female []

2. Age

15-19 [] 20-24 []

3. Class

a) Form 1 []

b) Form 2 []

c) Form 3 []

d) Form 4 []

4. Religion

Christian [] Muslim []

Other (Specify) _____

5. Are you a member of the health club in your school?

Yes [] No []

6. For how long have you been a member?

a) 1 Year []

b) 2 Years []

c) More than 2 years []

7. How often do you meet?

a) Weekly []

b) Once in two weeks []

c) Once a month []

d) Once a term []

SECTION B: Mode of delivery of Reproductive Health Information

8. List 3 topics that you have recently tackled in your health club?

i)

ii)

iii)

9. How is the information presented to you in the clubs

a) Role Play []

b) Group Discussions []

c) Books Only []

d) Lecture []

e) Guest Speaker []

Other (Please specify) _____

10. Do you find the topics you cover in your club helpful?

Yes [] No []

11. Who gives/teaches the health information in the health club?

a) Peer Educator []

b) Guidance and Counselling Teacher []

c) Counsellor []

Other (Please specify) _____

12. Do you think the topics you have tackled in the club can help other students in your school

Yes [] No []

SECTION C: Issues affecting uptake and utilisation of health information

13. Do you tell your parents or guardians about the information you receive in the health club?

Yes [] No []

14. If yes do they approve of it?

Yes [] No []

15. Who are the people that support your involvement in the health club?

- a) Parents and guardians []
- b) Teachers []
- c) Friends []
- d) Schoolmates []

Other (Specify) _____

16. Do you discuss with your friends or schoolmates about the information you receive in your health club?

Yes [] No []

SECTION D: contribution of reproductive health information and education in addressing teenage pregnancies

17. To what extent do you agree with the following statements about reproductive health information?

a. The information I receive from the health club provided me with new knowledge about reproductive health

- a) Agree []
- b) Slightly agree []
- c) Strongly Disagree []

- d) Disagree []
- e) Slightly Disagree []

b. The information I have received helped me to make better decisions about my sexual health

- a) Strongly agree []
- b) Agree []
- c) Slightly agree []
- d) Strongly Disagree []
- e) Disagree []
- f) Slightly Disagree []

c. The information I have received made me think about the dangers of engaging in risky sexual practices that may lead to teenage pregnancies, early sexual debut, Sexually Transmitted Diseases etc.

- a) Strongly agree []
- b) Agree []
- c) Slightly agree []
- d) Strongly Disagree []
- e) Disagree []
- f) Slightly Disagree []

18. To what extent do you agree with the following statements about the health information you receive in the health clubs?

a. The information has provided me with new knowledge about unintended/unplanned pregnancies

- a) Strongly agree []
- b) Agree []
- c) Slightly agree []
- d) Strongly Disagree []

- e) Disagree []
- f) Slightly Disagree []

b. The health information I have received has helped me to know that both boys and girls have a responsibility when it comes to unintended pregnancy

- a) Strongly agree []
- b) Agree []
- c) Slightly agree []
- d) Strongly Disagree []
- e) Disagree []
- f) Slightly Disagree []

19. The information I have received made me think that one can still return to school even after giving birth

- a) Strongly agree
- b) Agree []
- c) Slightly agree []
- d) Strongly Disagree []
- e) Disagree []
- f) Slightly Disagree []

Appendix 5: Certificate of Field Work



UNIVERSITY OF NAIROBI
COLLEGE OF HUMANITIES & SOCIAL SCIENCES
SCHOOL OF JOURNALISM & MASS COMMUNICATION

Telegram: Journalism Varsity Nairobi
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Reg. No: KSD/6794/2019

Name: JUDY NYAMVULA AMINA

Title: HEALTH INFORMATION BEHAVIOUR CHANGE AMB TEENAGE

PREGNANCIES IN SECONDARY SCHOOLS: A STUDY OF NAIROBI COUNTY

PROF. HERON MUGAMBI
SUPERVISOR

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10.09.19
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Dr Samuel Siringi
ASSOCIATE DIRECTOR

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Reg. No: KSD/6194/2017

Name: JUDY NYAMVULA AMINA

Title: HEALTH INFORMATION, BEHAVIOUR CHANGE AND TEENAGE PREGNANCIES IN SECONDARY SCHOOLS; A STUDY OF NAIROBI COUNTY

PROF. HEZRON MOGAMBI 25.11.2019
SUPERVISOR SIGNATURE DATE

Dr Samuel Siringi 10/12/2019
ASSOCIATE DIRECTOR SIGNATURE DATE

Prof. Nchi Nchi 10.12.2019
DIRECTOR SIGNATURE/STAMP DATE

