



# Exploring the Opinions of Parents and Teachers about Young People Receiving Puberty and Sex Education in Rural Kenya: A Qualitative Study

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## **Authors' contributions**

*This work was carried out in collaboration between all authors. Author CLJ conceived, designed and conducted the study, analysed the data and wrote the first draft of the manuscript. Author NFF supported analysis of the data. Author LMR supervised the design of the study and provided critical feedback during analysis and write up. All authors have contributed to and approved the final version of this manuscript.*

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## **ABSTRACT**

In Kenya, one of the most significant public health concerns is the spread of HIV. Additionally, 13,000 girls drop out of school every year due to pregnancy. Although the Kenyan Ministry of Education and other independent organisations have tried to implement various means of developing puberty and sexual health education for young people, the situation is not improving.

**Aims:** To explore the opinions of teachers and parents in rural Kenya about delivering puberty and sex education and to identify their perceptions of barriers to young people accessing this education.

**Study Design:** Qualitative study.

**Place and Duration of Study:** Rural Nyanza Province, Western Kenya between January and March 2013.

**Methodology:** semi-structured interviews with 19 teachers and 30 parents following a topic guide to explore their opinions about what young people need to learn about sex education and perceived barriers to accessing that education. The interviews were

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transcribed and subjected to Framework analysis.

**Results:** Analysis revealed a lack of continuity in teacher training for sex education and discrepancies in what is being taught in schools. It also highlighted internal contradictions in teachers' and parents' views about some aspects of sex education, particularly the emphasis on abstinence and negative attitudes towards contraception.

**Conclusion:** Strategies for improvement may include a full evaluation of the formal sex education curriculum and retraining where necessary to ensure consistency in the sexual health messages that are delivered to young people. Additionally, parents and wider rural communities may need to be better supported in their ways of discussing puberty and sexual health with their children.

*Keywords: Qualitative; sex education; Kenya; parents; teachers.*

## 1. INTRODUCTION

In Kenya, one of the most significant public health concerns is the spread of HIV. The majority of new HIV infections are in the 15-24 year old age group [1]. Additionally, 13,000 girls drop out of school every year due to pregnancy [2]. This is unsurprising as 86% of girls aged 15-19 do not use contraception [3], resulting not only in their increased exposure to HIV and other sexually transmitted infections (STIs) but also to early pregnancy. It is well established that there is a strong link between sexual health education and improved sexual practices [1,4,5].

Formal education about puberty, sex and sexual health is controlled by the Kenyan Ministry of Education. This includes an HIV/AIDS curriculum and a 'life skills' curriculum, which states that learners will acquire knowledge about HIV/AIDS prevention, personal and social behaviours that reduce the risk of infection and to show compassion for those infected [6]. Sex education is now an integrated subject in the curriculum, meaning that many classes should contain a brief mention of a prevailing issue in sex education. Given the commitment by the Kenyan Ministry of education in 2003 to provide nationwide access to free primary education for those aged 6 to 12 years [7] it would seem that structures are in place to deliver universal and standardised sex education.

Previous research has established the importance of an organised programme for sexual health education. A study in 2007 conducted an evaluation of primary school educational HIV intervention in the Nyanza province and established that pupils' knowledge about HIV, contraception and self-reported sexual behaviours in schools which had implemented a comprehensive HIV education scheme were improved compared to those without a comprehensive scheme [8]. The conclusion of the study was that the intervention "met local challenges and concerns" but there was no investigation of opinion among local parents and teachers.

Existing studies have also raised questions about the ways in which formal sex education provision operates in practice. Qualitative work in the Eastern and Rift Valley provinces reported that a number of teachers felt insufficiently trained to deliver lessons in the HIV/AIDS curriculum [9]. The few who did feel able to discuss fully the topics of sex education and health felt that this was at times at odds with the abstinence based message of the Ministry of Education. The study also found that pupils felt unable to approach their teachers with their questions for fear of being labelled as "bad mannered". The evidence

indicates that there are flaws in the current system of sex education, both in what is taught to pupils and the manner in which this information is provided.

Aside from children being taught about sex education at school, another source of information may be their parents. Crichton et al. explored mother-daughter communication about sex through focus group discussions in Nairobi slums [10]. They reported that there were many barriers to effective communication including lack of knowledge and shyness on the part of the mothers. However, as the data were part of a larger study on menstruation, other aspects of sexual health may have been overlooked. Additionally, the study focused exclusively on mother-daughter communication. Bastien et al. [11] found, in their review, one study examining parent-child communication about sex and HIV/AIDS that was conducted in Kenya [12] and two that compared Kenya to the USA [13,14]. In the former, Mbugua reported that mothers in Nairobi relied on the school system to provide sex education due to the general feeling that socio-cultural and religious inhibitions prevented them from discussing sex with their daughters [12]. Like Crichton et al. [10], the study did not look into how boys might receive sex education from their parents. The studies comparing Kenya to the USA were the only studies to examine a rural population in Kenya. This is significant as there are likely to be differences in exposure to sex and sex education between rural and urban populations, where most other research on this topic has been carried out. In their comparison to the USA, Poulson et al. stated that 38% of Kenyan parents believed that discussing sex with their children would encourage them to have sex [13]. This is a view reflected in the Njue et al. interviews with teachers with respect to educating pupils about contraception; some teachers believed that if you explained what condoms were, pupils would feel encouraged to try them [9].

It is also important to examine the manner in which children are taught about puberty, sex and relationships. Research suggests that the majority of sex education, be it by parents or in schools, is in a didactic, uni-directional style, offering warnings and threats with little or no room for questions and open discussion [9,11,13,14]. Students often reported that they would be punished for asking questions or believed that their confidentiality may be breached [9].

Several alternative schemes have been set up in recent years in an attempt to fill the gap in school or parent teaching; these were reviewed by Agbemenu et al. [15]. However, any that were not HIV/AIDS and abstinence centred already were encouraged by the Ministry of Education not to discuss contraceptives with the students. In some cases, school teachers discouraged the pupils from attending the lessons, some even going so far as to make sure there were no rooms available for the teaching or refusing to supervise sessions. The study found that many of the projects were unsustainable, not just due to teacher, Ministry of Education or community opposition but because many required IT resources that are not readily available, particularly in a rural setting.

Furthermore, several studies have indicated that there remains a disparity between what is taught and understood and what is being practised. Nzokia found that in spite of knowledge about condoms and other contraceptives, girls in Makueni District were not using them due to inability to obtain them, fears about side effects and the desire to adhere to religious teachings [16].

This research project was designed to address several gaps in existing research. The opinions of teachers or parents concerning sexual education has rarely been studied in rural Kenyan populations, particularly in Nyanza province, where no qualitative research has been

identified, despite it having the highest HIV prevalence in the country [17]. Previous studies have focused mainly on HIV/AIDS, and have been less concerned with other aspects of puberty and sexual health. While this may be understandable given the importance of addressing HIV/AIDS, it may be that a wider perspective can illuminate the barriers to improved sexual practice. A premise for the research is that the opinions of teachers about the course content that they are expected to deliver will assist in making a judgement about the effectiveness and relevance of sex education in Kenya. Only one paper has qualitatively focused on teachers' perceptions about sex education and the research was conducted in 2004 [9]. The focus of this work was the HIV/AIDS syllabus and other aspects of sex education, such as puberty and sexual health were not explored. In addition to considering formal structures, parents can be a vital source of information about sex education. This research project aimed to establish what parents feel is appropriate, and what they are able to teach their children about puberty, sex and sexual health. It is hoped that this will reveal areas for the improvement of the sex education offered in a manner that is both informative to young people and socially and culturally acceptable to parents and teachers in the community.

## **2. METHODOLOGY**

This qualitative study took place between January and March 2013 using topic guided face-to-face semi-structured interviews.

St. Vincent de Paul's mission hospital provided a base for the study. Purposive criterion sampling was used to obtain roughly even numbers of teachers from 5 schools and to ensure participants fit the criteria required. In some cases, convenience sampling was used to recruit further participants until data saturation was reached.

### **2.1 Data Collection**

To recruit teachers, staff at the hospital identified all schools within reasonable travelling distance of the hospital. These schools were then approached by the lead researcher and invited to take part in the study. All of the five schools approached accepted. The researcher then interviewed between three and five teachers at each school depending on the availability of staff (interviews were carried out during break and lunch times). Teachers in the staff room were given a brief introduction of the project and asked if they would like to participate. Volunteers were then taken to a private room for a full explanation of the project, completion of a consent form and the audio-taped interview. When recruiting parents, translators provided by the hospital approached people in the community with a scripted introduction of the project and a request to participate. If the participant agreed, a location was chosen by them for a detailed description of the project, completion of a consent form and the interview. There were no refusals to participate.

In order to be recruited as a parent, the participant had to be a parent or person with parental guardianship of a child/children aged nine and over. This age was determined as it is the lower end of the range of ages at which children have been reported to commence puberty. Similarly, teachers had to be teaching pupils who were aged 9 or over. It was not a requirement of participation that teachers specifically taught sex education lessons, for two reasons. Firstly, research indicates that integrated teaching is practised in most schools. This means that sex education may be incorporated into different types of lessons across a range of subjects and so it would form part of the teaching experience and practice of most

teachers. Secondly, the questions were designed to be hypothetical, and build on teachers' experiences by asking participants what they thought should be taught. This was so that the aim of exploring opinions was met, rather than conducting a survey of teaching practices. All participants had to be able to consent to the audio-taped interview and be willing to speak freely in front of a translator, if necessary.

The interviews followed semi-structured topic guides designed to address the key aims of this research. Teacher interviews explored the content of teaching, views on what should be taught and perceived barriers to students accessing optimal sex education; for example, 'What do you think children should be taught about puberty / contraception / HIV/AIDS / sexually transmitted infections?'. Parental interviews initially explored whether parents provided any informal sex education and subsequently considered parents' opinion on what children needed to know and whether parents were willing and able to meet these needs. Questions were simple and allowed parents to voice their own opinions, for example, 'What do you think young people should be taught about growing up?' with subsequent probing to explore issues further. In both cases discussion about content was broken down into: puberty, what sex is, HIV/AIDS and other STIs, pregnancy and contraception; these being considered to be the core of a well-structured sex education curriculum. Where participants did not spontaneously contribute their views on these topics, the interview was directed to address them by the researcher. To enhance consistency, the interviews were all conducted by the lead researcher (CLJ).

## **2.2 Data Interpretation**

Framework analysis [18] was selected due to limited prior research into this area. This method enabled codes to be derived from familiarisation of the data without imposition of preconceived themes. The open questions of the topic guide were designed to reflect this aim. After transcription of the semi-structured interviews, data familiarisation was achieved in accordance with framework analysis by the lead researcher (CLJ) producing detailed written summary notes of each transcript, identifying the key issues raised. Subsequent categorisation and thematic generation were developed by the lead researcher (CLJ) using qualitative data analysis software NVivo 8 [19]. The transcripts were then independently reviewed by a second author (NFF). The themes generated by the two authors were discussed and confirmed.

The data from parents and teachers were analysed separately. Due to significant overlap in the themes generated, the results are discussed together, integrating the two groups to allow triangulation of themes raised and concise data presentation.

## **3. RESULTS**

In total, 49 participants were recruited (30 parents and 19 teachers) and participant demographics are presented in Table 1.

Of the 49 participants, 43 were from the Luo tribe. The 19 teachers taught a variety of subjects. Their teaching experience ranged from one to 23 years. Among the 30 parents, the mean number of children was 3.8 (standard deviation 1.85). The ages of the children spanned between two months and 35 years but only children aged 9 or over were discussed. All of the children of school age attended school apart from one 14 year old girl who had dropped out due to pregnancy.

**Table 1. Participant demographics**

<b>Teachers</b>		<b>Parents</b>	
<b>Gender</b>		<b>Gender</b>	
Male	11	Male	6
Female	8	Female	24
<b>Age</b>		<b>Age</b>	
Mean	37.47	Mean	36.23
Standard deviation	11.12	Standard deviation	10.12
<b>School</b>		<b>Education level</b>	
Primary (pupils aged 6-15)	8	Primary	4
Secondary (pupils aged 14-19)	11	Completed primary	8
<b>Qualifications</b>		<b>Secondary</b>	
Diploma	9	Completed Secondary	10
BA	6	Higher	3
		<b>Translator needed?</b>	
MA	4	Yes	9
		Part	7
		No	14

Participants spoke about 4 core aspects of sex education and the results are presented below under each of these themes.

### 3.1 Content of Sex Education Teaching

The first aspect to be considered is the content of the sex education syllabus. The research set out to explore how the content of the formal syllabus was delivered in practice and how parents discussed sex education with their children informally. The key research questions are around the ways in which parents and teachers interpret the broad messages of the syllabus, and what they choose to emphasise and minimise.

Both teachers' and parents' central focus was the importance of abstinence.

*"The important thing is to leave such things like sex"-parent, female, 30.*

*"We emphasise on abstinence"-teacher, female, 24.*

The main reason given to pupils as to why they should abstain was a warning about disease or early pregnancy. The principal concern among teachers was that the severity of HIV/AIDS was misunderstood and that this would lead to carelessness in their students:

*"They don't fear, it's come to be normal so you need to teach them more"-teacher, male, 28.*

Teachers also voiced concern that with the current treatment for HIV/AIDS, people living with HIV/AIDS do not look ill which has the double effect of being unable to tell who is infected, therefore making people more likely to engage in sex with someone who is infected and reducing the perceived severity of HIV/AIDS:

*"...now there are ARVs, you can't tell who's infected"-teacher, female, 42.*

Most teachers stated that they explained the symptoms and treatment of HIV to their pupils, with many also informing them about gonorrhoea and syphilis. In contrast, while most of the parents mentioned either HIV/AIDS or other non-specific STIs or “diseases”, the conditions were not fully explained to their children and simply named as a vague abstract warning.

Though the HIV/AIDS syllabus includes a section about encouraging students to have compassion for the infected, some teachers mentioned there was still stigma about HIV:

*“...they make fun at school”-teacher, female, 42.*

However, the general impression was that the stigma surrounding early pregnancy was more pronounced:

*“There is a lot of stigma either outside the school or within the school”-teacher, male 32.*

This stigma was supported by teachers’ own perceptions of the impact of pregnancy. Often considered as severe, if not more severe than HIV/AIDS, many teachers highlighted that early pregnancy would ruin a girl’s education:

*“...you become a mother when you’re still young, your education will stop at that point. It will affect you your whole life”-teacher, female 48.*

In general, parents were also more concerned with early pregnancy than with the risk of disease. Their concern lay not only in that pregnancy would mean the end of their daughters’ education but also that the burden of looking after the baby would fall on them as well as their daughter:

*“...if you mess up that is the end of you”-parent, female, 37.*

*“...the child shall not be taken care of by the father and it shall again be a burden on me”-parent, female, 40.*

One of the parents interviewed had a 14 year old daughter who had recently dropped out of school due to pregnancy. The participant cried when she spoke of her daughter’s pregnancy, and her feelings of helplessness in the situation:

*“...in case she [daughter] did abortion, she may even die and the blame is on me”-parent, female, 30.*

She was one of two parents who mentioned abortion, illegal in Kenya except in circumstances in which the mother’s life is in danger. Two teachers mentioned discussing abortion with their students and the risks involved. One teacher discussed at length the back street abortions that were being performed in the community, some by nurse aids:

*“It is illegal but on the other hand it is a reality...they would not be doing it like an official thing in hospital but they would be doing it back street”-teacher, female, 39.*

Another topic frequently warned about was the impact of a young person’s social environment on their level of sexual activity. A number of participants discussed the “bad”society that they were living in and the influence that it could have on the behaviour of

young people. Among the teachers, this mostly consisted of warning the pupils not to go out alone at night or be tempted by offers from strangers:

*"We tell them not to walk during night hours, they can get bad men who can rape them"*-teacher, male, 27.

*"They lure our girls with small money"*-teacher, female, 37.

A few teachers also mentioned that peers may pressure young people into sex. In spite of these acknowledged risks, almost no participants mentioned coaching their children or students in self-esteem or assertiveness. One teacher explained the problem as a cultural barrier:

*"In the African culture in most cases you find that the girl will just do the head maybe shyly look down and you note the boy, it's like the girl is accepting so in that case I bring out the idea that you have to be assertive"*-teacher, female, 39.

Among teachers and parents there was a general reluctance to discuss contraception with young people. Most parents talked about abstinence as the only way to protect yourself from getting diseases or pregnant:

*"Interviewer (I): would you talk to them about how you can prevent pregnancy?"*

*Participant (P): yes*

*I: what would you tell them?"*

*P: don't trust any guy because they can cheat you easily"*-parent, female, 30.

Both parents and teachers demonstrated the prevailing belief that talking about condoms is encouragement to have sex:

*"I feel it was dangerous to tell them there's something that can control...now they just don't care"*-teacher, male, 56.

*"You cannot encourage them to use condoms because that will encourage them more"*-parent, female, 25.

Among the teachers there was an acknowledgement that despite lessons about abstinence, their students were sexually active:

*"We preach abstinence but the truth is that many of these young kids are sexually active"*-teacher, female, 39.

The teachers also gave many other reasons for why condom use should not be encouraged in their students. These included the idea that condom use should be as a 'last resort':

*"...for those who cannot abstain then you can opt for the contraceptives"*-teacher, female, 48.



Several teachers highlighted the issue that, with the majority of the schools in the region being owned by the Catholic church, teaching about contraceptive use conflicted with the teachings of the church:

*"...being this is a Catholic school, we try to talk about abstinence, don't use condoms, things like that"*-teacher, female, 42.

Most reasoned that contraceptives were also called 'family planning' and therefore they should only be used in the future, when the students have families:

*"... 'til marriage, that's when they can access this or that contraceptive"*-teacher, female, 24.

Very few parents mentioned discussing puberty. Only five of the 30 parents mentioned menstruation when asked what important information their children should have about growing up. Only one parent said they would tell their child what sex actually is.

In parallel with this, teachers demonstrated an awareness of the dearth of information provided by parents and discussed the consequences of not informing children about puberty in advance:

*"...they think that they are sick, we tell them they are becoming adults, it is normal"*-teacher, male, 51.

### **3.2 Method of Delivery**

The second theme concerns how the sex education curriculum is delivered. Research focused on the perceived advantages and disadvantages of different organisational models, and also explored teachers' and parents' views of their ability to deliver education.

Discussion with the teachers about how the sex education teaching was organised varied hugely both within and between schools. There was mention of integrated teaching, separate teaching, a 'life skills' curriculum, 'health club' where students could debate issues including sex education, and guidance and counselling support with no formal structure or continuity.

Overall, teachers were of the opinion that integrated teaching is effective as it allowed the students to put sex education into the context of their own lives:

*"...when you relate to it you see oh sure this thing is real"*-teacher, male, 32.

Some teachers felt that integrating sex education into the wider curriculum meant that teachers, ranking it as a low priority in their lesson, would just skip over the content. These teachers wanted to see additional separate teaching of sex education:

*"It should be something that is taught as a unit"*-teacher, female, 42.

#### **3.2.1 Feelings about delivering information**

Most teachers felt comfortable and happy to talk to their students about sex education:

*"I enjoy it, I feel like I am protecting them"*-teacher, male, 28.

However, some, particularly the older teachers for whom training in delivering sex education was lacking, acknowledged that they were fighting against their cultural instincts:

*"It was African culture that there was that fear, though we are trying to fight it"*-teacher, male, 56.

Most parents were unwilling to discuss sex education with their children in spite of awareness that this could cause problems in the future:

*"...we are afraid to expose our kids, we are afraid to face reality which is hurting our kids"*-parent, female, 30.

### **3.2.2 Source of information**

Teachers focused on the idea that teaching is the responsibility of society as a whole:

*"It should not be particular to anyone, we are all responsible"*-teacher, female, 37.

In addition, teachers did express feelings that the parents should do more to educate their children about sex:

*"...parents should talk about it, they should not wait until the children know about these things from other sources"*-teacher, male, 50.

Interestingly, despite expressing a reluctance to discuss sex education with their children, most parents felt that it was a parent's responsibility to inform their children about sex. There was almost an awareness that traditions needed to change but an uncertainty about how to go about it:

*"We as parents should adjust tradition and make more interest to our children to talk to them"*-parent, female, 45.

Half of the parents felt it was the mother's responsibility to educate the children about sex education because she has the closest relationship to the children:

*"The way outside people see the child and the way the mother sees the child it's a different perspective"*-parent, female, 32.

*"I designate to the mother to discuss with them, I cannot continue those issues"*-parent, male, 50.

### **3.3 Perceived Barriers**

The third aspect of the research concerned the identification of reasons why young people may not be receiving adequate sex education. A deliberately broad view was taken of potential barriers, and respondents identified a wide range of barriers, including social and cultural impediments as well as systemic barriers within the education system.

Several barriers to young people accessing appropriate puberty and sex education were raised. In many cases, teachers spontaneously identified barriers whereas parents were

likely to state there were no barriers. However, other things mentioned by the parents confirmed some of the barriers identified by the teachers.

### **3.3.1 Cultural barriers**

Most teachers felt that the main barrier is that “traditional culture”, in which sex is a taboo subject, hinders the teaching of sex education:

*“It’s very difficult attaching this to traditions which are restrictive in nature”-teacher, male, 50.*

### **3.3.2 Religious barriers**

Many teachers felt that the content of sex education teaching is restricted by the church influence in the schools:

*“Personally I am trying to break the barriers but you have to be very careful... it’s a war that has been there for a quite a long time, this issue of contraception versus the church”-teacher, female, 39.*

Furthermore, though the region is mostly Catholic, one teacher had experience of working in a Muslim school, which had presented a further set of problems:

*“...somebody who is not a Muslim talking to Muslims about sex was another issue”-teacher, male, 50.*

### **3.3.3 Parental factors**

Participants also identified that several parental factors acted as a barrier to young people receiving sex education. One such factor was parental ignorance resulting in their inability to discuss puberty and sex with their children:

*“If you were brought up in a funny way, you cannot bring your child up in a better way”-parent, female, 30.*

Additionally, there was the issue of parental absence, mostly due to employment pressures, though occasionally due to neglectful behaviour, that meant some parents were not present to discuss these topics with their children:

*“...when they come home, most are tired, some are drunk and some avoid the children”-teacher, male, 51.*

It was also acknowledged that financial pressures may prevent young people from attending school. Though advertised as ‘free primary education’, the reality is an unregulated system in which schooling for primary age children is subsidised by the government but still costs parents fees which are determined by the teacher for each individual pupil:

*“They cannot access education because your parents have to pay the fees”-teacher, female, 24.*

Additionally, some students will not start primary school until they are much older, if their parents cannot afford it, and therefore may already be past puberty by the time they reach the class that teaches this.

### **3.3.4 The education system**

The lack of continuity and consistency in the course content was considered a barrier to sex education in that the delivery of sex education was at the teacher's discretion and there was no means of regulating what is being taught to the students:

*"The truth on the ground is some classes are going untaught"-teacher, female, 39.*

*"It's like everybody's coming up with their own ideas, let us try life skills, they try another medium then let me try this, churches also saying let us also try this programme so people are not speaking with one voice and when there is no consistency it means it leads to more confusion"-teacher, female, 39.*

Some teachers also indicated that the didactic and authoritarian demeanours of some teachers may negatively impact on the receptiveness of the students to sex education teaching:

*"Where there is a teacher who is feared by the students is to go and start talking about sex education to the students, they're going to freeze"-teacher, female, 39.*

In addition to this, some teachers expressed that they found it difficult to relate sex education to their students because of their difference in age. Many felt that perhaps peer education would be a viable solution to this issue:

*"Others might be having issues which they fear telling their parents or telling the teachers but they can be free to share with their peers"-teacher, male, 32.*

The inconsistencies in teacher training were also apparent. Of those for whom it was not part of the curriculum when they trained as teachers, some have attended seminars and are well informed; others have just used their initiative. Some teachers explained that during their training, most teachers focused on the subjects they would later teach and only those with a special interest in guidance and counselling gave the module any attention:

*"...is that person trained? Is that person having the capacity to deliver the lessons? I think sex education would require re-training of the teachers in some of these areas because um because otherwise it would be like a blind person leading another blind person, some of us also need sex education. If you personally are not suitably aware there's no way you can help another person"-teacher, female, 39.*

The few teachers who had received further training to teach sex education found the experience positive in terms of their attitudes and confidence in delivering sex education to their students:

*"We were taught...I found out we were doing a wrong thing pretending...after I was desensitised, I saw the reality and I just opened up"-teacher, female, 50.*

### 3.4 Potential for Change

The final research theme considered what changes were required, and how change may be brought about. The research questions here brought together issues around the content of the curriculum, how it is delivered, and means of removing barriers in considering ways forward.

Teachers identified a need for the restructuring of sex education teaching in schools and universal retraining of the teachers so that a consistent and continuous message can be delivered:

*"...there is a gap and it is a glaring gap...there is no consistency and it leads to more confusion"*-teacher, female, 39.

*"...it would require structured curriculum then training"*-teacher, male, 30.

Many teachers introduced the idea that sex education should start with the parents:

*"Parents can be desensitised so that they get rid of these cultural beliefs that hinder sex education"*-teacher, male, 30.

In light of this, parents subsequently interviewed were asked if they would like further sex education and some teaching in how to approach this topic with their children. All 15 parents asked this question said they would like more training in the subject to improve their knowledge and encourage them to be open in discussing sex with their children:

*"...maybe I don't know a lot...there I may learn officially"*-parent, male, 52.

*"...if we have a seminar, I will gain strength to be open"*-parent, female, 35.

*"...if there was a programme to go out and educate, the way the HIV started at first people will shy off but you see it has reached a point very few are shying off but people are coming out just to do the test and if we could have had programmes for those things for such maybe going even out to schools it could be very nice"*-parent, female, 40.

## 4. DISCUSSION

This study provides original insight into Kenyan teachers' and parents' perceptions of sex education and is the first study to examine parents' and teachers' opinions together. This means that a broad view of the delivery of sex education can be ascertained, thus providing a new understanding of the barriers to young people receiving relevant sex education. Although undertaken in a small population, it is reasonable to believe that the results discussed here would be replicated in similar rural and tribal populations.

The primary themes evident in the data are content of sex education teaching, preferred methods of delivery of this education, perceived barriers to young people accessing sex education and potential for change.

The Kenyan government's recognition of the importance of sex education in addressing continuing HIV infection and pregnancy in young people is evidenced by the number of

initiatives launched [6,15] in the last few years. However, in spite of government commitment and policy action, the measures do not appear to be effective when considering the high incidence of sexually transmitted infections and teen pregnancies [1,2,3]. While the Ministry of Education has put in place a series of measures designed to specify how sex education should be taught, the approach has tended to be ad hoc and piecemeal, and there does not appear to be a structured assessment of what is effective and what is not. While it may be seen as positive that there is scope for individual teachers to modify the syllabus and the teaching practice, for example, to take into account local requirements, it may be that the approach has become overly fragmented and dependent on individual teacher preferences. This finding agrees with research carried out by Boler et al. who reported selective teaching of HIV/AIDS in Nyanza Province [20].

This research suggests that, while the Kenyan government's support for the importance of sex education is recognised, the method of implementing the approach through proposing frequently changing, and often inconsistent, methods has led to increased uncertainty among teachers about how they may best deliver sex education in schools.

In addition to inconsistencies in how sex education is taught, there is disparity in what is actually taught. Although there is a formal syllabus, discussions with teachers revealed discrepancies in content within and between schools depending on teachers' views about the importance of different aspects of the subject. This lack of coherence is exacerbated by the attempts of international agents or local (often religious) authorities to provide what they perceive to be appropriate sex education. Many teachers saw the need for a restructuring of the sex education syllabus so that a consistent and continuous message is delivered. If the focus of any future reform is on content, then a strong syllabus could be designed and implemented according to available resources.

One of the key research findings was the view expressed by most teachers and parents that the core message of a sex education programme should be the prescription of abstinence. While the desirability of abstinence was explained by some interviewees in the context of encouraging the continuation of education, the overriding rationale was provided by reference to the traditional cultural setting, including the strong religious influence. Parents and teachers expressed concerns that if the message was anything other than abstinence then it would constitute an explicit encouragement of early sexual behaviour. To some extent, this is a false dichotomy as it is unlikely that any sex education programme would encourage early sex. Other research supports this in finding no correlation between sex education and increased sexual behaviour [21,22,23]. Nonetheless, this logic then extends to an unwillingness to discuss contraception, as this may be perceived as tacit encouragement for early sexual activity.

Many teachers and parents were aware of the internal contradictions between belief and practice. For example, a frequently expressed view was that condoms were something that should be used for family planning in the future, but their use was not appropriate before marriage, while simultaneously acknowledging an expectation that young people would have sex before marriage.

The internal contradictions which are a factor in discouraging the use of contraception apply also when teenagers become pregnant. While elective abortion is illegal in Kenya, it was widely recognised that it happens and that it has serious physical and psychological risks. The focus on abstinence, coupled with an unwillingness to discuss contraception, means

that strategies for managing the consequences of sex without contraception have perhaps not been subject to sufficient attention.

One aspect of the emphasis on abstinence is the way in which it is framed. The general presentation highlights dire consequences for those who do not abstain, whether in terms of health risks or unwanted pregnancy. The effect is negative, and generally based on promulgating fear of behaving otherwise. A broader message of abstinence as the outcome of a positive choice may empower young people to choose to abstain positively rather than based on misinformation or fear.

To some extent, the attempt to inculcate an element of fear of HIV in support of abstinence is perhaps becoming less effective. Some teachers expressed a view that HIV/AIDS is downplayed in severity by their students. This is interesting, as it contrasts with results reported in other studies. Volk et al. reported that participants in Kisumu found AIDS the disease that scares them the most and concluded that educational efforts have successfully communicated the disease severity [24]. It may be that, as this study was conducted in 2001, the new generation of students, with the wider availability of HIV management drugs and their direct experiences of people who are living normal lives with HIV have a reduced perception of disease severity. It is a difficult balance between emphasising that HIV and AIDS are serious diseases without removing all hope of a relatively normal and healthy life for those who are already infected.

By including interviews with parents, this work considered the less formal communication of information about sex in the form of parents' discussions with their children. Generally, results show that these dialogues tended to focus on the dangers of pregnancy and HIV/AIDS rather than broader information about puberty, sex and contraception. This contrasts with the work of Crichton et al, who reported that mothers did talk to their daughters about menstruation and pregnancy [10]. However, the results reported by Crichton et al may have been artefact as they were part of a larger study on menstruation, and so the interviewing had a different emphasis. The parental focus on prescribing abstinence linked with fear of the consequences of not abstaining makes it difficult for parents to help their children to develop strategies for coping with puberty or being sexually active.

Many of the participants extended the fear of direct consequences of not abstaining to a more widespread disquiet about "the bad world of today", with concerns about their children being pressured into sex by peers, influenced by contemporary culture, being persuaded into sex in exchange for money or being raped. The negative framing of abstinence means that, in spite of this awareness, very few participants were able to formulate strategies to encourage self-esteem and assertiveness among their children, particularly young girls.

By interviewing parents and teachers, the findings of this research provide useful insights into issues of how sex education is taught in Kenya. There is an overall consensus that sex education is an important tool in addressing health concerns such as the increasing proportion of young people with HIV, and the growing rate of teen pregnancy. However, this research found that there may be an ad hoc approach to teaching practice. Although the content of the syllabus is formally prescribed [6], the emphasis is primarily on abstinence, framed in terms of punishment for wrong doing for those who do not abstain, and this view predominates both in the formal education process and in informal communications from parents.

#### **4.1 Implications for Interventions**

In Kenya, the availability of suitable and sufficient resourcing is likely to be a constraint on all interventions. Indeed, the background paper to the 2007 World Development Report stated that teacher training in HIV/AIDS cannot be implemented simultaneously across Kenya due to insufficient trainers and resources [25]. It could be argued that, while the Ministry of Education has tried to address sex education by proposing a number of measures and methods, resource constraints, mean that an alternative approach focussing on developing the content of the intervention first may have been more appropriate. The findings of this study suggest that the primary challenge of improving education is to find a way to deliver a consistent message which will be broadly acceptable to teachers and parents. If the focus was on developing a sex education curriculum of this nature, then even if resource constraints prevent simultaneous countrywide implementation, the syllabus should not require repeated revision and a consistent message could be delivered.

This research indicates that a key area to address in improving the teaching of sex education is the misconception that a sex education curriculum that includes information about contraception and sex is at odds with the cultural and religious imperative to insist on abstinence. Participants were often aware of the logical inconsistencies of their views, and of the contradictions between the beliefs and practices of young people. It is therefore important to emphasise that a broader sex education syllabus is unlikely to encourage greater levels of early sexual behaviour, but that better informing young people about sex and sexual health would encourage abstinence as a positive choice rather than an outcome based on fear.

The cultural beliefs of the wider community can present a practical barrier to young people practising safe sex. For example, the perception teachers had that students would not buy condoms because the shopkeeper would be likely to question them about it illustrates that even if sex education in schools is good, the views of the community can restrict the practice of safe sex.

It is therefore interesting to note that teachers emphasised a community responsibility for educating children, stating that parents should do more to informally educate their children about sex. In conjunction with this, parents were far more likely to state that it was the role of the parent, often the mother specifically, to educate the children about sex even if they simultaneously acknowledged that they did not do this. A key finding of this study is that there is the desire among many parents to educate their children about sex but that they feel ill equipped to practically achieve this. Vandenhoudt et al. explored the application of a US evidence based parenting intervention in the Nyanza province in 2004 and found that parents' attitudes regarding sexuality education changed positively, with 96% of participants finding it helpful [14]. However, their intervention required participants to attend 5 sessions which would reduce the likelihood that people would attend fully and would also likely be expensive to implement on a larger scale. A single session that delivered key information to parents to improve their knowledge of puberty and sexual health and to give ideas and encouragement to convey these topics to their children may be a more suitable solution. It is reasonable to assume that the extra training and education teachers have received to prepare them for teaching sex education has made them more comfortable with the issue and perhaps a similar, brief training session for parents could fill any gaps in their knowledge while simultaneously making steps towards eradicating the cultural taboo that surrounds sex education. Overall, it may not be necessary to challenge religious or cultural values but rather to reframe the issue of abstinence in a positive rather than a negative way.



## **4.2 Limitations**

All of the interviews with teachers were conducted in English. The extensiveness of the transcripts suggests that it is unlikely that using their second language hindered responses. Among the parents, fewer than 1/3 required a translator for the entire interview. The length of transcript was not markedly different between interviews with a translator and without and the impact of using a translator was therefore felt to be negligible.

Given the sensitive nature of the interviews, participants may not have fully disclosed their views but the data gathered were rich and diverse suggesting that open discussion was achieved and data were a valid representation of participants' opinions.

The majority of the parents interviewed were mothers. This is most likely because fathers are more likely to be the major breadwinner and were therefore unavailable for daytime interview. Future research to gain some more perspective into fathers' feelings about discussing sex education with their children may therefore be of use.

The extent to which the ethnic origin and gender of the interviewer (white female) acted as a limitation was considered. There may be some advantages associated with the position of "outsider", and the detachment of the interviewer from the community may have made participants more likely to be open about culturally sensitive topics. Additionally, many participants went to lengths to explain "our culture" which may imply that were the interviewer more familiar with local culture, they would not have been so extensive in their explanations. Overall, the length and depth of the data collected suggests that the interviewer's gender and ethnicity were not seriously limiting factors.

## **5. CONCLUSION**

This study highlights that teachers and parents in rural Kenya are united in recognising the importance of sex education for young people but the current approach needs to be improved. The analysis of responses suggests that a restructuring of the formal sex education curriculum is required to ensure consistent and continuous teaching. In addition a cultural shift is required in that both parents and teachers need to understand that there is little evidence that a broad sex education promotes early sex but rather can help young people to make informed and positive decisions about abstinence or healthy sexual behaviour. Parents are willing but ill-equipped to support their children in puberty and sexual health education. Perhaps a further area for intervention could be the education of parents with regards to their knowledge of sex education and adequately equipping them with appropriate strategies to convey this information to their children.

## **CONSENT**

All authors declare that written informed consent was obtained from all participants able to read and sign the consent form. Where this requirement could not be met verbal consent was obtained and translators confirmed this in writing.

## **ETHICAL APPROVAL**

In accordance with best practice for research conducted outside the researcher's home country approvals for this work were sought both in the UK and Kenya. Ethical approval was

obtained from the BMedSc Population Sciences and Humanities Internal Ethics Committee at the University of Birmingham, UK. This process involves independent review by a University approved board of three senior academic staff members. Changes to protocol were requested and made prior to receipt of a favorable ethical opinion. Approval was also obtained from the Chief of the Muhoroni district, Kenya.

## COMPETING INTERESTS

The authors have no competing interests.

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