EXAMINING THE PRACTICE OF SCHOOL BASED SEXUALITY EDUCATION PROGRAMME IN PRIMARY SCHOOLS IN BUGIRI DISTRICT

MYSTICA ACHENG JAMETO

2014-M282-20046

UGANDA MARTYRS UNIVERSITY

JANUARY 2017

Examining the Practice of School Based Sexuality Education Programme in Primary Schools in Bugiri District

A postgraduate dissertation

presented to

Faculty of Health Sciences

in Partial fulfilment of the requirements for

the award of the degree

Master of Public Health - Health Promotion

Uganda Martyrs University

Mystica Acheng Jameto

2014-M282-20046

January, 201

DEDICATION

This research dissertation is dedicated to my family: My best friend and husband Willy, Nathan Ethan, Czar; my Siblings the late Anthony, Nancy Hopkins, Allan, Ronald Regan, Peter and Petro; my parents Mr. John Ameto and Mrs Vento Ameto for your love, guidance, encouragement and unconditional sacrifice towards my education.

ACKNOWLEDGEMENTS

It is with humility that I give thanks to the Almighty God for His blessings that has brought me this far. My sincere appreciation further goes to everyone who made this study possible; I am grateful to you all. I am overwhelmingly thankful to my supervisor Ms Lillian Nantume Wampande whose encouragement, technical guidance and timely constructive criticism kept me going and believing in myself. Am further indebted to all lecturers in the Faculty of Health Sciences for the knowledge they imparted in me.

I am truly grateful to Paul, Paul Lule who drove me safely to the field during data collection process. Finally my special appreciation goes to my family Willy, Nathan Ethan, Czar; my siblings, Dad and Mum; whose sacrifice, unrelieved encouragement and enthusiasm enabled me pursue the course, may God bless you all abundantly.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
Et al	and others
HIV	Human Immunodeficiency Virus
MOES	Ministry of Education and Sports
SIECUS	Sexuality Information and Education Council of the United States of America
STI	Sexually Transmitted Infection
UDHS	Uganda Demographic and Health Survey
UN	United Nations
UNCRC	United Nations Convention on the Rights of a Child
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WHO	World Health Organization
CSOs	Civil Society Organizations
SEPSPEL	South Eastern Private Sector Promotion Enterprise Limited

OPERATIONAL DEFINITIONS

Sexuality Education

This is a lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles (SIECUS, 2014).

Abstinence-only sex education programmes

Sex education programmes that "focus on abstinence from sexual intercourse, typically until marriage" as the only method of preventing unwanted pregnancy and/or the spread of STDs (Kirby, 2000).

Abstinence-plus sex education programmes

This is a sex education programmes that teach abstinence as well as the use of contraceptives to prevent pregnancy and the spread of STDs (Kirby, 2000).

Adolescent

An adolescent is defined by World Health Organization (2014) as a decisive transition period in human growth and development between ages 10 and 19 years.

ABSTRACT

Background

Sexuality education has been highly controversial in Uganda in the past several decades. This comes as a result of perceived resistances from parents, teachers, religious leaders and law makers which are due to misunderstandings about the nature, purpose, and effects of sexuality education on young people (Boonstra, 2011; UNESCO, 2009).

Objective

This study intended to examine the practice of school based sexuality education in primary schools in Bugiri district. It specifically examined the type of sexuality education program available to pupils, determined the factors influencing the type of sexuality education delivered, and critically assessed the usefulness of existing sexuality education programmes in Bugiri district.

Methodology

The study was a cross sectional study design which was descriptive in nature. Both quantitative and qualitative techniques for data collection which include questionnaires, focus group discussion, interviews and documentary review were used to collect data. Purposive sampling was utilized to select teachers and key informants according to their knowledge about the topic being researched while pupils were selected randomly. The data collected was analysed using SPSS 16.0 for quantitative data while thematic analysis was used for qualitative data.

Results/Findings

The study found that the most commonly employed type of sexuality education was comprehensive education. Also, most of the teachers (72.2%) had integrated sexuality education lessons in other subjects and some teachers (26.5%) taught the lessons during co-curricular activities. While some teachers were not decided on a systematic way of teaching the subject. This means that there is no clear guidance at school level on how this type of education should be delivered thus, teachers did what was easier to practice. From the study findings time allocated to teach sexuality education was not adequate. The teachers indicated that most parents had positive attitude towards sexuality education. This is contributed to by the whole school approach used. The findings further indicated that the current practice of sexuality education in primary schools is poor (77.5%).This is due to the fact that sexuality education is not examinable hence teachers gave the subject less attention. Sexuality education was not part of teacher training curriculum, and there were no adequate facilities to facilitate teaching.

Conclusion

Comprehensive education formed the most common type of sexuality education delivered to pupils in primary schools. Although it was also found that not all the teachers were teaching all topics in the curriculum, some skipped other topics. This means that some pupils did not receive holistic information to influence behaviour positive change. Lack of adequate knowledge on sexuality education among teachers, limited resources and minimal time allocated for teaching sexuality education and believes influenced implementation of sexuality education curriculum in primary schools. Despite the critical importance and evidence justifying the need for sexuality education, the actual delivery of sexuality education in primary schools is still insufficient to help young people develop personal skills and influence behaviour change.

Recommendation

Government should harmonise sexuality education curriculum for primary schools. All primary schools should be involved in sexuality education to facilitate reach of adolescents at risk due to limited and sometimes inaccurate information regarding sexuality issues. The training of teachers on sexuality education should be integrated as part of the teacher training curriculum and government should introduce an in-service course for teachers on sexuality education. The districts should develop clear tools for monitoring implementation of school based sexuality education to ensure quality age appropriate information are provided to all pupils. The issue of misconception around sexuality education topics should be taken up as serious advocacy issues that require attention of all stakeholders.

CHAPTER ONE

INTRODUCTION

1.0 Background to the study

Enjoyment of the right to sexuality education plays a fundamental preventive role for adolescents' sexual related illnesses, and may be a question of life or death (UN Special Rapporteur Report on the Right to Education, 2010). More so, ensuring access to sexuality education information can help young people delay onset of sexual activity, reduce the frequency of sexual activity, reduce number of sexual partners, and increase contraceptive use (Kirby, 2001). Nearly two third of unhealthy adult behaviours and unhealthy choices such as early pregnancies are associated with conditions or behaviour that begun in adolescence (WHO, 2014). Such behaviour can also be connected to lack of exposure to necessary health information so as to guide decisions. Sexuality education at younger age is therefore a valuable instrument in a child's education to facilitate healthy growth and development.

Comprehensive sexuality education is therefore a very vital aspect of child's education amidst the threat of teenage pregnancy; unsafe abortions, HIV infections, and other Sexually Transmitted Infections (Motherway, 2010). Sexuality education in primary schools has the potential to be a powerful way to educate children and adolescents at a younger age about the risks and implications of early sex, which all place significant burden on families, communities, and upon scarce government resources (Kirby, 2001). As emphasized by Hodzic *et al (*2012), school-based sexuality education is still a growing concern to many stakeholders including; educationalists, child rights activists, and those within public health practice especially those advocating for behaviour change (Hodzic *et al,* 2012). Health promotion is particularly concerned because of the desire to promote healthy living through skills development and

behavioural change at an early stage when there is high likelihood to adopt change. It is also of concern because it can provide adolescents with increased capacity and opportunities to make healthy choices through facilitating access to information, knowledge and developing life skills (UNESCO, 2010).This is because people cannot flourish and achieve their fullest health potential unless they have control over things that determine their health (WHO, 1986).

This study is thus building on the Ottawa Charter for health promotion (1989), as a process of enabling people to increase control over and, to improve, their health. Additionally, it is building on the Bankok Charter (2005), by contributing information to address the determinants of health through school health promotion. The United Nations recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of everyday human being. It is important to ensure that health promotion interventions are based on a set of principles centred on the concept of empowerment to enable people to develop skills to take more control over the determinants of their health (Laverack, 2007). In this view, schools are important setting through which empowerment actions can be implemented. The WHO emphasised the concept of school health education that it should focus on behaviour and conditions that promote health or that put health at risk including developing life skills needed to adopt healthy behaviour. Sexuality education is therefore part of school health education aimed at equipping young people with skills necessary to adopt healthy life choices and behaviour.

Sexuality Education is a lifelong process of acquiring information and forming attitudes, beliefs, and values about such important topics as identity, relationships and intimacy (SIECUS, 2004). Defining identity and relationships are very important aspects in a person's development (Weinreich, 1986). The knowledge of a person's identity contributes to developing personal skills and empowering individuals through; promoting self-awareness, developing interpersonal

skills, communication, decision-making, assertive, and negotiation skills, as well as the ability to create reciprocal and satisfying relationships. Similarly, attitude, beliefs and values of a person shapes identity and relationship by improving critical-thinking skills, increasing self-esteem and self-efficacy, and developing insights concerning relationships with family members, individuals of all genders, sexual partners, and society at large (Erikson, 1968). The beliefs, desires, and behaviours of a person are affected by social preferences, relationships, and the social contexts in which a person lives and make decisions (Tomasello, 2014). In other words, the environment in which adolescents live and the relationships they have are very instrumental in influencing adolescents' choices and behaviour. Evidenced based sexuality education programmes are vital in shaping this behaviour by developing personal skills, reducing adolescent risky sexual behaviours and promoting health (UNESCO, 2009).

Sexuality Education is an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, and non-judgmental information. Thus, the primary goal of sexuality education is to promote a positive and respectful approach to sexuality, being free from diseases, violence, injury, fear, false beliefs, unplanned pregnancy, and equip young people with information, values to take responsible choices about their sexual and social relationship (UNESCO, 2009; UNFPA, 2015). Sexuality education further aims at helping young people acquire skills to make informed decisions including ability to understand, synthesize and correctly apply knowledge and skills gained (UNESCO, 2010; SIECUS, 2004). Thus, shaping attitude about factors that mitigate incidences of adolescent pregnancy.

Adolescent as defined by World Health Organization (2014) is a period of human growth and development that occurs after childhood and before adulthood between the ages of 10 to 19. However, the characteristics of this stage can extend up to the age 24 (UNICEF, 2009). This

period is transitional full of physiological, and social changes that are often misunderstood by adults and the adolescents alike (Uganda National Health Policy, 2004). At this stage, adolescents do not view selves as children, but as adults capable of leading own life, while the adults view them as immature and unable to handle major responsibilities. In this regard, personal Skills building are important because, it is at this stage that risk -taking behaviour of various dimensions including health is very influential and prevalent in adolescents' life (Uganda National Health Policy, 2004). Adolescents' risks taking appear to be caused by different development courses (Linda *et al,* 2010). Good sexuality education must therefore, provide adolescents with honest, age-appropriate information and skills necessary to help them take personal responsibility for their health by developing appropriate skills to make informed decision and choice based on factual information (UNESCO, 2009).

Internationally, the importance of sexuality education as prevention strategy to adolescent pregnancy has been greatly emphasized (UNESCO, 2009; WHO, 2010), but its comprehensive implementation has still remained a challenge. Yet, young people need access to unbiased, and scientifically accurate information to allow them develop the skills necessary to avoid risky sexual behaviour (WHO, 2010).

In Uganda, the Presidential Initiative on AIDS and Ministry of Education and Sports introduced school based sexuality education to all primary schools in 2002, and was integrated in the primary school curriculum. However, the implementation of sexuality education curriculum in primary schools in Uganda is still unknown (Kibombo et al, 2008). This delay in coverage and implementation is attributed to perception that sexuality education is against culture and religion, or that it leads to early sexual debut (Boonstra, 2011). Implementation of Sexuality education in Uganda is therefore still weak (Bankole et al, 2007), as there is lack of guidance on effective

implementation. As a result many adolescents in Uganda are denied the opportunity to access information, develop personal skills necessary to make informed healthy choices.

Even though implementing comprehensive sexuality education programmes remain a challenge in many parts of the world, the need for young people to receive high quality comprehensive sexuality education is recognized (UNESCO, 2009). Furthermore, Kirby (2007) asserts that implementation of school based sexuality education programmes as a prevention strategy, has the capacity to reduce high sexual practices among adolescents. This means that, classroom teachers have a responsibility to act in the place of parents to ensure the protection and wellbeing of adolescents (UNESCO, 2009).

The United Nations Special Rapporteur‘s Report on the Right to Education (2010), of the sixty-fifth session with a theme on Promotion and protection of human rights: Human rights questions including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms, emphasized the need for sexuality education as a human right in itself. It is a crucial way of realizing other human rights by not only providing access to information, but access to scientifically accurate and correct information. This report introduced the topic of the right to sexual education, putting it in the context of patriarchy and control of sexuality. It explained the interdependence of sexuality, health and education and the relationship of this right to other rights from a gender and diversity perspective. It tackled the situation of the right to sexual education, bringing state responsibility into account, not forgetting the critical role of the family and the community in ensuring that this right is fulfilled (Vernor, 2010).

The challenge of ensuring that sexuality education is a right that adolescents as rights-holders are able to hold states and other "duty-bearers" accountable for guaranteeing and fulfilling still

remains across many countries (UNFPA, 2012). Even though school settings provide a significant opportunity to reach large number of adolescents with vital information on sexuality before they become sexually active, there is a lot of controversy in many countries on what topics can be discussed with the young people (Moreno *et al*, 2008).

The controversy about sexuality education has therefore affected the method and nature of sexuality education delivered to young people in Uganda (Blum, 2004). Even with heightened global attention to the importance of sexuality education, the development and implementation of national school-based programmes in many countries have not been achieved. Even then the factors that contribute to effective successful implementation of school-based sexuality education are unclear at country, district, and school levels (UNESCO, 2010). Nevertheless, all young people are entitled to access to right information that is age appropriate, and absolute (WHO, 2010). If this is hidden from them, they will receive conflicting and sometimes damaging messages from other sources, and it is therefore clear that good sexuality education balances this through by providing correct information and having emphasis put on values (UNESCO, 2009).

In Uganda, talking with young people about issues of growing up, body changes, sex, condom use, and relationships among others are regarded as taboo and inappropriate in the cultural context for many societies (Musiimenta, 2013 and WHO, 1993). For instance discussing about contraceptive use and sexual matters with young people in most areas in Uganda is accompanied by difficulties in expression, silence, and embarrassment. This complicatedness created by shame, and disapproval of open discussion of sexual matters by adults, including parents and teachers, at the time when it is needed most cripples implementation (UNESCO, 2009). More so, factors such as teacher pre-service education, teaching background, confidence, practical experience, and teachers' personal values makes the situation worse. As teachers do not receive

the necessary preparation to deliver sexuality education. This therefore deprives adolescents the access to accurate sexuality knowledge, life skills and ability to make informed decision about pregnancy. It is however, recognized that teaching social skills relevant to sexual behaviour in classroom settings requires exceptional expertise both in programme design as well as in delivery by teachers (UNESCO, 2014). This means that, the quality of the program offered is very critical if young people are to gain the knowledge to make informed decision, avoid early pregnancy, and lead healthy lives.

Uganda has a high teenage pregnancy rate of 24% (UBOS, 2011), which limits their ability to make informed decision, lowers their self-esteem and ability to live healthy lives. Teenage pregnancy further increases the risk of maternal death for Adolescents and limits their future employment opportunities, (Amin *et al,* 2013). It is unfortunate that these high figures exist yet, Uganda has in place laws such as the Constitution of Uganda, Children's Act, and the Penal Code Act criminalizing sexual act with a person below 18 years old. The dissemination of these laws and policies is questionable.

Many factors are further attributed to this high rate of teenage pregnancy and among them is the fact that today adolescents are entering adolescence earlier and healthier and are more likely to have sex before marriage (Heather, 2011). Yet, the fact remains that, quite often, adolescents do not receive even the most basic accurate sexuality education and that misinformation about sex and its consequences remains common among adolescents. If this misinformation is not addressed the consequences associated with lack of skills and information regarding sexual health will continue to prevail (UNESCO, 2009). Thus, denying many adolescents the right to grow, develop and realize their full potential.

The high teenage pregnancy rate is also attributed to by the myths surrounding issues of sexuality. In a study conducted by Straight Talk Foundation, several myths and misconceptions were found to exist among teenagers in Uganda. For instance, 54% of adolescents think a girl cannot become pregnant the first time she has sex (Straight Talk Foundation, 2013). This means that more than half of adolescents are at risk of becoming pregnant due to lack of factual information regarding sex. Sexual and reproductive ill- health are among the major contributors of disease burden among adolescents (UNSECO, 2009; WHO, 2014). Yet, this burden can be prevented and reduced by providing adolescents with accurate and non-judgmental information that promotes personal skills development and ability to make informed decision to live healthy lives. The need for effective sexuality education is therefore vital to equip adolescents with accurate, relevant information, and support them to develop skills to lead healthy lives. It is upon this background that this research tried to establish the factors influencing implementation of school based sexuality education in primary schools in Bugiri district.

1.2 Statement of the Problem

In Uganda, talking with young people about issues of sexuality is regarded as taboo, inappropriate in the cultural context for many societies, and is accompanied by difficulties in expression, silence and embarrassment (Musiimenta, 2013; WHO, 1993). This difficulty created by shame, and disapproval of open discussion of sexual matters by adults, including parents and teachers, at the time when it is needed most influence the teaching of sexuality education in many schools (UNESCO, 2009). Due to this discomfort, Sexuality education has not been part of the national curriculum. However, it was being taught in Ugandan schools through an assortment of extracurricular activities including drama, dance, and music (Jacob et al, 2007). It was not until 2002 when the President of Uganda Yoweri Kaguta Museveni launched a national initiative

to fight HIV/AIDS. This initiative was to incorporate HIV/AIDS education in primary and secondary education throughout the country. Instruction was to begin at the primary level and later was to be incorporated into five subjects at secondary level. However, this remained more of a paper document and was not implemented in many schools. The recent studies in Uganda have reported that implementation of sexuality education in schools in Uganda is still weak (Bankole et al, 2007). This is because the actual delivery in primary schools remains poor and ineffective, and misconception was eminent, barely have the primary schools abided by the president's initiative (UBOS, 2013). Even the few schools that seem to teach some few aspects, little is known about the extent to which classroom teachers are prepared to make possible sexuality education (Marla *et al,* 2010)

It is also reported that sexuality education has been highly controversial in Uganda in the past several decades (Bankole *et al*, 2007). This is so owed to a number of perceived resistances, which are due to misunderstandings about the nature, purpose, and effects of sexuality education. As a result, the majority of adolescents do not receive adequate preparation for their sexual lives. Thus, leaving them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexual transmitted infections (UNESCO, 2009).

Ugandan adolescents stand a risk of making wrong choices when it comes to sex because they lack access to comprehensive, scientifically accurate and realistic information about sexuality. Only 33.8% girls and 22% boys aged between 12 and 14 have received sexuality education in school (Guttmacher Institute, 2008). Yet, 71% of girls and 64% of boys had never talked with parents about sex-related matters at home (National Survey of Adolescents, 2004). As a result, Uganda's teenage pregnancy rate continues to be high, at 24% (UBOS, 2011). Yet, adolescents who give birth are not only susceptible to poor healthy choices, but also early marriage, which

exposes them to early parental responsibilities, and intimate partner violence. This means that these adolescents are denied the right to grow, develop and realize their full potential (Amin et al, 2013). School health education should therefore view health as more than absence of disease; should focus at enabling young to promote conditions supportive of health and support young people to develop life skills needed to adopt healthy behaviour. This study therefore sought to understand the type of sexuality education program, determine factors influencing the nature of sexuality education program, and assess the usefulness of existing sexuality education programmes in primary schools in Bugiri district.

1.3 Objectives of the Study

1.3.1 Main objective

To examine the practice of school based sexuality education programmes within primary schools in Bugiri district.

1.3.2 Specific Objectives

1. To examine the types of sexuality education program available to pupils in primary schools in Bugiri district.
2. To determine the factors influencing the nature of sexuality education programmes in primary schools in Bugiri district.
3. To critically assess the usefulness of the existing sexuality education programmes in primary schools in Bugiri district.

1.4 Research Questions

1. What type of sexuality education program are available to pupils in primary schools in Bugiri district?

2. What are the factors influencing the nature of sexuality education programmes delivered in primary schools in Bugiri district?
3. How useful could the prevailing sexuality education programmes be in primary schools in Bugiri district?

1.5 Scope of the Study

This section analyses the thematic scope, the geographical scope, and the time scope.

1.5.1 Thematic Scope

The study looked at the nature, mode of teaching, and factors influencing the practice of sexuality education within primary schools so as to find out how it is being used as a tool to instil behaviour change among pupils in primary schools in Bugiri district. Factors influencing implementation of sexuality education programmes in primary schools were examined and these included teacher training, sources of information, time allocation, mode of teaching and cultural factors. The question of whether the existing nature of sexuality education programmes and teaching method used would be effective in instilling behaviour change among primary school pupils was also highlighted in the due course of the discussion.

1.5.2 Geographical Scope

The study was conducted in primary schools in Bugiri district. The district was chosen because it has previously experienced high rate of adolescent pregnancy most of which immanent from primary schools.

1.5.3 Time Scope

The research was conducted within a period of seven month (January 2016 to August, 2016) in fulfilment of a requirement for completion of the study by the Uganda Martyrs University.

1.6 Significance to Public health and health promotion practice

This study will guide implementation and point out the bottlenecks associated with the school based sexuality education. Appropriate nature and method of teaching sexuality education that influence adolescents' sexual behaviour and inspire elimination of teenage pregnancy among vulnerable school pupils was pointed out. This could steer health education decision-making in primary schools and, perhaps could be adapted and cultured in the practice of school based sexuality education programmes, and its impact on adolescents' health. UNESCO (2009), in its international guidelines on sexuality education recommended factors for effective implementation of sexuality education.

Kirby (2001), further described characteristics of effective sexuality education programmes. The study has therefore tried to understand how the type of sexuality education provided and teaching method being used promote access to accurate, complete information, and skills development to promote positive behaviour change among primary school pupils in Bugiri district. This study is adding to attempts by State and non-State actors to equip adolescents with vital skills necessary to make healthy choices at early stage during development (UNFPA, 2015; UNECO, 2012; Kirby, 2009; Kirby, 2001; Bankole *et al.* and 2005; Boonstra, 2011).

1.7 Justification of the Study

Schools are critical venues for health education and improving health outcomes (WHO, 2009). Adolescents spend most of their time in school than at home, yet misinformation regarding sex remains high among the adolescents in many districts in Uganda including Bugiri district (Straight Talk Foundation, 2009). Bugiri district is in East central region of Uganda with the highest rate of teenage pregnancy at 30.6% against the national average of 24% (UBOS, 2011). It is therefore important to understand whether the nature of sexuality education and mode of

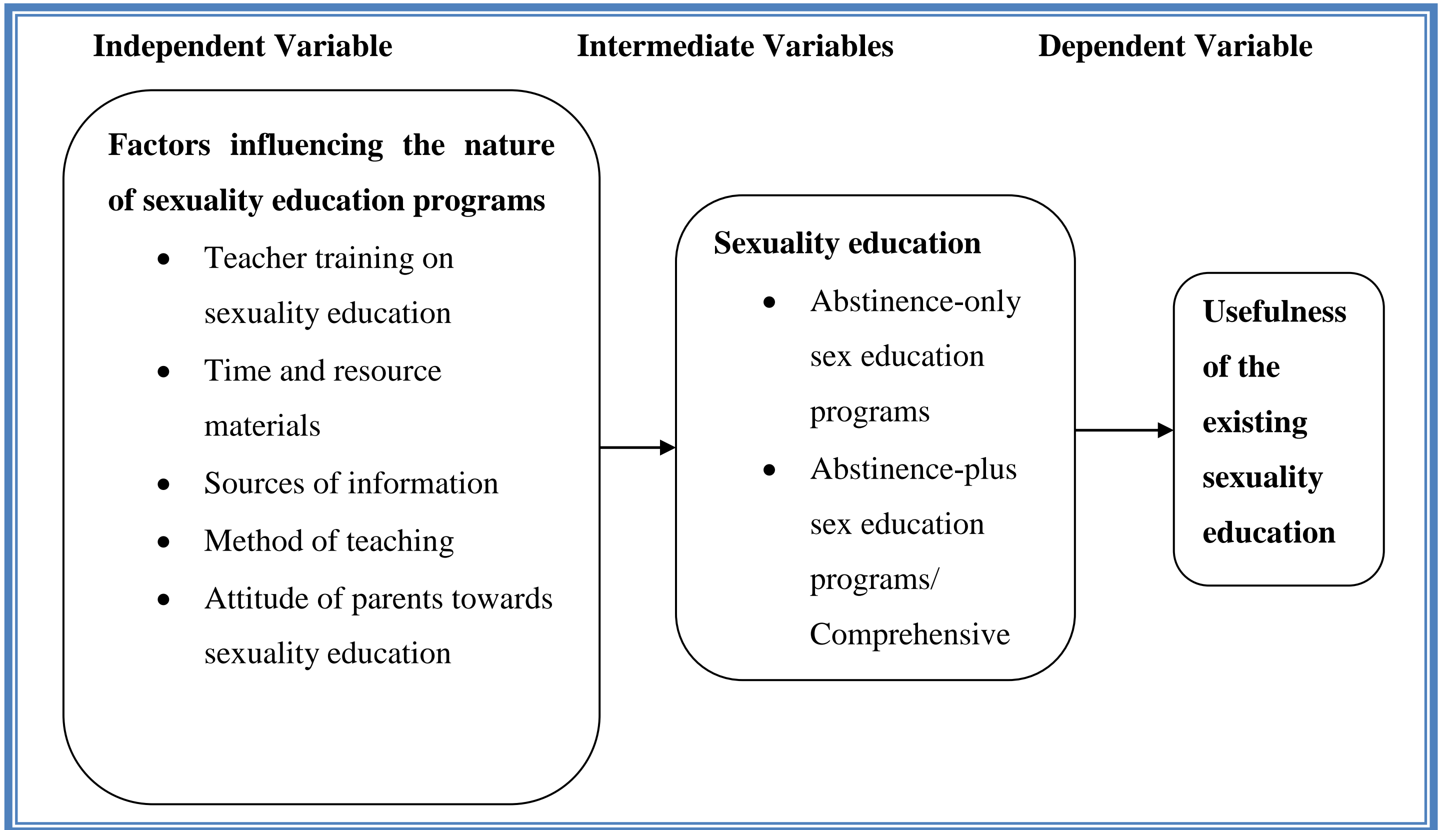
teaching used provide adolescents with appropriate, scientifically accurate, and non-judgmental information.

There are clear arguments that scaling up sexuality education through the formal school curricula is the best and most effective way of mainstreaming sexuality education (UNESCO, 2011). Additionally, Research clearly shows that comprehensive sex education programmes do not encourage adolescents to have sexual intercourse (Fonner *et al.*, 2014); do not increase frequency with which teens have intercourse; and do not increase number of a teen's sexual partners (Kirby, 2001). Thus, empowering individuals to take control of their health determinants and improve healthy living.

Therefore, contributed to the scholarly body of knowledge on implementation of school based sexuality education as ingredients to healthy adolescent growth and development. Strategic factors that lead to effective delivery of school based sexuality education in primary schools will be identified and suggested to add to the existing models in the effective design and dissemination of sexuality education. It will inform decisions aimed at inspiring communities and schools to transform attitude on sexuality education.

1.8 Conceptual Framework

Figure 1: Factors influencing the nature of sexuality education programmes



Source: SIECUS, 1996

The concept is that usefulness of the existing sexuality education programmes may be impacted on by sexuality education either through abstinence only sex education programmes or by abstinence plus sex education programmes (Kirby, 2000). It is hypothesised that the nature of sexuality education program in primary schools might result into increase in the usefulness of the existing sexuality education programmes. It is also hypothesised that usefulness of the existing sexuality education programmes may also be influenced by factors like teacher training on sexuality education, time and resource materials, and sources of information, method of teaching and attitude of parents towards sexuality education.

This research recognised the fact that there are many other factors that may influence the usefulness of sexuality education, but this dissertation placed emphasis on teacher attributes and how they influence the outcome. Given the ultimate importance attached to other factors by public health, other research should be conducted to explain those other factors, which were not emphasised in this dissertation.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents a review of the literature on which this study was based. It reviewed studies conducted by other authors and researchers on the implementation of sexuality education in schools while identifying knowledge gaps that helped in designing primary data collection tools for collecting data to bridge these gaps.

2.1 Sexuality education in the context of public health and health promotion

United Nations Population Fund (UNFPA, 2010) defined Sexuality as a social construction that characterizes the understanding and experience of sex, gender and sexual orientation. UNFPA in its International Conference on population and development held in Cairo in 1994 recognizes Sexuality Education as a human right essential to development and human wellbeing. Comprehensive and non-discriminatory sexuality education is therefore based on the rights protected by several human rights agreement including; the Convention on the Rights of the Child (UN, 1989), the International Covenant on Economic, Social and Cultural Rights (UN, 1966), the International Covenant on Civil and Political Rights (UN, 1966), the Convention on the Elimination of All Forms of Discrimination against Women (UN, 1979); and the Convention on the Rights of Persons with Disabilities (UN, 2007).

In 2015, UNFPA came up with new Operational Guidance for Comprehensive Sexuality Education, and sexuality education is defined as a right-based and gender-focused approach to sexuality education, whether in school or out of school. The new UNFPA's definition was

developed in conformation with the International Conference on Population and Development's Programme of Action and the Commission for Population and Development resolutions of 2009 and 2012. In this regard, comprehensive sexuality education holds a holistic view of sexuality and sexual behaviour: it is age-appropriate, curriculum-based education that aims to equip children and young people, according to their evolving capacities, with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality (UNFPA, 2015).

The Oregon department of education presents basically 3 approaches to sexuality education. Comprehensive education and it emphasizes that abstinence is the only 100% effective way to prevent HIV/STI's and unintended pregnancy. It however, does not exclude medically accurate, age-appropriate information and instruction about condom use and other forms of contraception. The second approach is Abstinence-only, which emphasizes that abstinence is the only responsible choice outside of a long-term, monogamous relationship and medically accurate information about condom use and other forms of contraception is usually not included. Thirdly, Abstinence-only until marriage which emphasizes that abstinence is the only choice outside the context of a heterosexual marriage and medically accurate information about condom use and other forms of contraception is usually not included (Oregon Department of Education, 2015).

Sex education that focuses on abstinence is based on the belief that encouraging young people not to have sex until marriage is the best way to protect against adolescent pregnancy. This approach limits sexuality education by not providing information about how young people can protect themselves from early adolescent if and when they do chose to have sex (UNAIDS/WHO 2008). Even though there are these various forms of sexuality education, there is evidence

pointing to the fact that comprehensive sexuality education is the most relevant approach to sexuality education as it delays onset and frequency of sexual activity (Kirby 2001).

As emphasised by the Sexuality Information and Education Council of the United States and National Guidelines Task Force (2004); all people have the right to comprehensive sexuality education that addresses the socio-cultural, biological, psychological, and spiritual dimensions of sexuality by providing information, exploring feelings, values, and attitudes; and developing communication, decision-making, and critical-thinking skills (UNFPA, 2010).

Rassjo and Kiwanuka (2010) listed sexual problems such as forced sex and teenage pregnancy as being common among adolescents, especially in developing countries like Uganda. Yet, these could be reduced by sexuality education (UBOS, 2013). The global increase in teenage pregnancy, human immunodeficiency virus (HIV) infection rates and sexual violence is making school-based sex education a growing concern to many stakeholders internationally (Hodzic *et al,* 2012). In due course, efforts by World Health Organization (WHO) and UNESCO to universally standardize sexuality education, have emphasized the need for young people to access unbiased and scientifically truthful information to permit development of essential skills that determine individual sexuality (WHO, 2011 and UNESCO, 2009).

UNFPA and UNESCO (2012) in a study indicated 30% of the population in developing countries is below the age of 15 years, and notably many adolescents do not receive satisfactory and dependable information related to sex, gender and sexuality. Kirby (2007) asserts that school based sexuality education programmes as a prevention strategy has capacity to reduce high sexual practices among adolescents. Thus, reducing unplanned pregnancy. In this regard,

classroom instructors have a responsibility to ensure the protection and wellbeing of adolescents (UNECO, 2009).

Policy and school level debates have focused on what constitutes appropriate content and approach of teaching school based sexuality education in the last few decades (Amir *et al*, 2012). However, little is known about the extent to which classroom teachers are prepared to make possible sexuality education (Eisenburg *et al.*, 2010). Equally the depth of training, mentorship and coaching programmes that should prepare sexuality education instructors, do not adequately prepare them for the complex roles (Eisenburg *et al.*, 2010).

The international guidelines on sexuality education developed by UNESCO (2009), provides sexuality education learning objectives, which covers four components of the learning process. This includes, information, sexuality education should provide accurate information about human sexuality, including growth and development, sexual anatomy and physiology, reproduction, contraception, pregnancy and childbirth, HIV/AIDS, STIs, family life and interpersonal relationships, culture, gender rights, empowerment, equality and gender roles, sexual behaviour, sexual diversity, sexual pleasure, sexual abuse, gender-based violence, and harmful traditional practices. The second learning objective centred on Values, attitudes and social norms: sexuality education should offer students opportunities to explore values, attitudes and norms (personal, family, peer and community) in relation to sexual behaviour, health, risk-taking and decision-making and in consideration of the principles of tolerance, respect, gender rights and equality (UNESCO, 2009; Kirby, 2007).

Additionally, the third learning objective focused on Interpersonal and relationship skills. Sexuality education should promote the acquisition of skills in relation to decision-making,

assertiveness, communication, negotiation, and refusal. Such skills can contribute to better and more productive relationships with family members, peers, friends and romantic or sexual partners (UNESCO, 2009; SEICUS, 2004). Furthermore, the fourth learning objective is, Responsibility Sexuality education should encourage students to assume responsibility for their own behaviour as well as their behaviour towards other people. This is through the strategies of respect, acceptance, tolerance and empathy for all people regardless of their health status or sexual orientation, insisting on gender equality, resisting early, unwanted or coerced sex, and practicing safer sex, including the correct and consistent use of condoms and contraceptives (UNESCO, 2009; UNFPA, 2010).

In view of the earlier mentioned objectives; UNESCO, 2009 specified topics under which learning objectives have been defined and are organized around six key concepts including; Relationships, Values, attitudes and skills, Culture, society and law, Human development, Sexual behaviour, Sexual and reproductive health. With this in mind, ensuring that young people have an adequate knowledge of sexuality topics is evidently important, and at one level, programmes that are successful in doing so have achieved worthwhile objectives (Kirby, 2007; UNFPA, 2010).

At another level, it is now recognized that, to meaningfully impact on the sexual health of adolescents, sexuality education must go beyond increasing knowledge. It must equip young people, not just with factual information, but also with the tools to adopt behaviours that enable them to reduce sexual health problems such as unintended pregnancy and enhance sexual health (UNESCO, 2009). Therefore, effective sexuality education should involve a series of educational activities that help adolescents to acquire the information, motivation, and behavioural skills to maintain and improve their health (WHO, 2011; UNESCO, 2009).

Just as importantly, a growing body of research has provided educators with a set of key elements that form the basis of effective sexuality education programmes (Stanger *et al*, 2011, UNESCO, 2012). Relatedly and based on a broad review of the literature on teen pregnancy prevention programmes, Kirby (2001) developed a list of ten Common Characteristics of effective Curricula. Including that; they should focus on reducing one or more sexual behaviours that lead to unintended pregnancy or STD/HIV infection. They must be based on theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviours.

The above set-up is in line with WHO concept of school health education that focuses on Behaviour and conditions that promote health or put health at risk (WHO, 1995). Additionally, effective curricula should give a clear message about sexual activity and condom or contraceptive use and continually reinforce that message (Kriby, 2001; *Stanger, et al* 2011; UNFPA, 2012). Effective programmes should provide basic, accurate information about the risks of teen sexual activity and about methods of avoiding intercourse or using protection against pregnancy and STDs (Kirby, 2001; UNECSO, 2009; Stanger *et al* 2011). Similarly, effective programmes should include activities that address social pressures that influence sexual behaviour. They should provide modelling of and practice with communication, and negotiation skills (Kirby, 2001; WHO, 2012; UNFPA, 2015). Also, effective programmes should employ a variety of teaching methods designed to involve the participants and have them personalize the information. They incorporate behavioural goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students (Kirby, 2001; UNFPA, 2015). Effective programmes should last a sufficient length of time to complete important activities adequately. They should select teachers or peer leaders who believe in the programme

they are implementing and provide them with training (Kirby, 2001; UNESCO, 2009, UNFPA, 2012). This means that any programmes which does not share these characteristics may not be effective in providing young people with knowledge and skills needed to take control of their own sexuality. Good programmes should therefore try to bare this characteristics.

While a growing body of evidence exists to demonstrate the constituent of an effective school-based sexuality education program (Kirby, 2001), factors that contribute to effective successful implementation of school-based sexuality education are unclear at regional and country levels (UNESCO, 2010). For instance, in China, the political will and commitment to respond to HIV and AIDS was significant in scaling up of sexuality education in schools. In this regard school based sexuality education is delivered in all secondary schools through health education, and it is integrated within the different subjects (UNESCO, 2010).

In most African countries including Nigeria, Kenya, and Uganda sexuality education is being conducted in contexts where it is a sensitive issue (Eva *et al*, 2010), unlike in other countries such as Netherlands where it is not a sensitive issue (UNESCO, 2012). This sensitivity of the topic therefore has related consequences on the pace at which sexuality education programmes can be introduced, the content of sexuality education, and the willingness of the teachers to implement.

During an international consultation on sexuality education (2011), it was concluded that comprehensive sexuality education should be expanded so as to provide accurate information about contraceptives to adolescents (WHO, 2011). According to Columbia University study published in the American journal of public health; 86% of the decline in teenage pregnancy in the United States was attributed to improved use of contraceptives. While only a 14% decrease

was associated to reduced sexual activity. Additionally, the United Kingdom Independent Advisory Group on teenage pregnancy suggested that recent research confirms greater efficacy of contraceptive use over abstinence only (Ross *et al*, 2014; Stanger *et al*, 2011)

While Sexuality Information and Education Council of the United States and the National Task Force (2004) described the Uganda sexuality education as comprehensive, involving promoting abstinence for those who wish to remain sexually inactive, and use of condoms for preventing of STI and unwanted pregnancy, Rubin *et al* (2009), reported that sexuality education in Uganda is less comprehensive, where faith based organizations emphasized behavioural change on what they called abstinence and fidelity as the sole emphasis, condom use is not mentioned. Equally UNFPA and UNESCO in a 2012 review of Ugandan sexuality education school curricula found that, there were many false statements about condoms and contraceptive methods. However, such teaching approaches do not prevent sexual activity among adolescents. The adolescents are therefore left ignorant about how to protect themselves against unwanted pregnancy.

Additionally; the same review by UNFPA and UNESCO (2012) found that Uganda has a fairly long-standing school based sexual health education programme. The life planning skills for primary and secondary (2009) and the adolescent sexual reproductive health for ordinary level curriculum series (2009) were reviewed. Topics were found to be incorporated across multiple school subjects; Biology, English, Christian Religious Education, Islamic Religious Education and Geography. The life planning skills for primary and secondary education was considered more comprehensive than the adolescent sexual and reproductive health for ordinary level.

Findings by PATH (2003) indicated decision making and negotiation skills geared towards sexuality needed more emphasis. Also, the extent to which the topics are effectively taught was

questionable given the fact that some teachers felt uncomfortable teaching sensitive topics. Since it is not examinable, sexuality education was deemed unimportant. Some inaccurate information that requires reconsideration were also noticed: for instance sexuality definition as 'having sex appeal and being sexy' is misleading, sexiness is a quality of a person whereas sexuality is a dimension of life (UNFPA and UNESCO, 2012). Some topics like homosexuality seem to be intentionally removed, thus pointing to the conclusion that a large portion of the curriculum is not taught. Yet, curriculum based sexuality education if taught appropriately can help adolescents to develop life skills like communication, enhance self-esteem, improve decision making skills, and can also lead to positive and equitable relationships (UNESCO, 2014).

Even though school settings provide a significant opportunity to reach large numbers of adolescents with vital information on sexuality before they become sexually active. There is a lot of controversy in many countries on what topics can be discussed with the teenagers (Moreno *et al*, 2008). Despite all these limitations on sexuality topics to be discussed Moreno *et al*, in a 2008 study of Provocative Questions in Parochial Sex Education Classes found that young people are more curious about awareness of sexual practices. Therefore, the roles of school sexuality education programmes and that of parents in providing adolescents with correct and unbiased information should be noted. Even then, it makes an economic sense to ensure sexual and reproductive health of adolescents. Since the sexual and reproductive ill- health are among the major contributors of disease burden among adolescents (UNESCO, 2009). Provision of sexuality education in schools is thus an important strategy towards the achievement of Sustainable Development Goals; *(3) Ensuring healthy lives and promote well-being for all at all ages, (4) Ensuring inclusive and equitable quality education and promote lifelong learning*

opportunities for all (5) Achieving gender equality and empower all women and girls (1) End poverty in all its forms everywhere.

There is therefore need to integrate comprehensive sexuality education into formal school curricula. The quality of the programme offered is very critical if young people are to gain the knowledge and lead healthy lives (UNESCO, 2014). Curriculum based sexuality education if taught appropriately can help adolescents to develop life skills like communication, enhance self-esteem, improve decision making skills, and can also lead to positive and equitable relationships (UNESCO, 2014). Schools are critical venues for health education and improving health outcomes (WHO, 2009). UNESCO (2011) presents clear arguments that scaling up sexuality education through the formal school curricula is the best and most effective way of mainstreaming sexuality education.

2.2 Factors that influence successful execution of sexuality education in schools

Teacher training is fundamental to the successful delivery of sexuality education in schools, and yet efforts to train teachers are often inadequate, if in place at all. For example, teachers in Malawi report not receiving any training on sex education. In Uganda many teachers have opted not to teach about sex education as a result of inadequate training (UNESCO, 2008). Teachers are not likely to have experience dealing with these issues in class, and require specialized training so they are comfortable discussing them without letting personal values conflict with the health needs of the learners (UNESCO, 2009).

In 2007 it was reported that a number of states in India had decided not to implement the Adolescent Education Programme in its present form, rejecting the material that had been supplied. Many young people across India are still not receiving information about sexuality

(National AIDS Control Organization, 2008). Although, offering sex education at school is a principal method of reaching large numbers of young people, there are 75 million children around the world who are either unable to go to school or decide to drop out of school (UNESCO, 2009). In order to ensure that all young people are reached with basic sex education, programmes that target young people outside of school are essential. Young people who are in school also benefit from receiving further information about sex from other sources, adding to and reinforcing what they learn in school (UNESCO, 2009).

Good quality risk reduction education relies on trained and skilled human capacity, (UNAIDS, 2001). Apart from the social and cultural constraints that exist in teaching sexuality, a number of obstacles faced by teachers are symptomatic of a wider crisis in education. Efforts in the classroom are hampered by oversized classes' dearth of training opportunities for teachers and limited learning materials (Boler *et al*, 2003).

Some teacher training institutions in Southern African Development Community (SADC) countries and universities have succeeded in developing institutional policy on sexuality education. They have also integrated sexuality education in curricula and implementation of training, support and counselling services for learners and teacher (UNESCO, 2006). There is also limited available information to date on sexuality pre-service teachers' programme for teachers in Sub-Saharan Africa, and most of the information does not offer hard data on measuring effectiveness of such programmes (UNESCO, 2006).

A study carried out by Boler and Jellema (2005) on teacher training in Zambia concluded that poorly trained teachers are often too shy to teach sex education. The study further concluded that such teachers also lack commitment to teach the topics in an often over-crowded curriculum.

Another study carried out in Mauritius Institute of Education on doorway innovative teaching and learning approaches by Bholah and Gungdeen (2007) stated that the government of Mauritius strongly supported all policies linked to sexuality education. Hence the institute has integrated sexuality Education into various training programmes in both primary and secondary curricula thus, improved the teaching of sexuality education.

Whether a particular education system is of high or low quality can be judged by input, output and process. Due to financial constraints, government of Ethiopia chose to improve quality of education through teaching and learning process, which is assumed cost-effective. The study aimed at finding extent to which innovative approaches of teaching and learning are employed in primary school in Ethiopia. Descriptive survey research on method used found most teachers still use lecture method to teach sexuality education (Derebssa, 2005).

For scholars quality of education depends largely on teaching-learning process. It is therefore cognizant of this situation that employment of learner-centred pedagogy is essential (Cook and Cook, 1998). Learning by doing is a theme stressed by many educators since John Dewey's time where learners are engaged in an active quest for learning new ideas (Dewey, 1966). Silcock and Brundert (2001) define learner -centred approaches as those where tutor guides facilities learners other than asserting control, towards targeted teaching goals. Active learning and teaching involves use of strategies, which maximize opportunities for interaction. Some literatures make reference to interactive rather than active approaches.

Effective sexuality education encourages young people to participate and engage with the information that is being presented to them by offering them the opportunity to apply it (UNESCO, 2009; UNFPA, 2015). Group work and role play are particularly important methods

in which students might discover the practical aspects of the information they are given (UNFPA, 2015). These methods allow pupils an opportunity to practice and build skills – saying "No" to sex. Active learning approaches are widely considered to be most effective way for young people to learn health- related and social – skills (UNICEF, 2009). Further more active leaning offers an opportunity to make sexuality education lessons fun. Sexuality education classes can be constructed to involve quizzes, games or drama, and can still be very effective learning sessions (UNFPA, 2015).

Parents and community share the task of promoting positive learning in young learners (World Bank, 2002). Parents were frequently assumed to object to teaching of reproductive health. Some parents cited religious or cultural beliefs prohibit them from discussing sex with their children (Pettifor et al, 2007; Welling's *et al*, 2009). Several parents mentioned teachable moments as they arose from TV programmes or adverts to discuss sexuality with their children. Opponents of Sexuality Education in schools felt that they were not prepared to discuss Sexuality Education at home or other reproductive health topics either due to embarrassment or lack of knowledge (Pettifor *et al*, 2007).

Another obstacle to effective sexuality education for young people in schools is adults who determine the curriculum (Avusabo *et al,* 2008). The adults' parents' curriculum planners, teachers or legislators – often consider the subject to be too "adult" for young people. There is also obstruction to adequate sexuality education from adults who are also concerned that teaching young people about sex, sexually transmitted infections, HIV and pregnancy, will somehow encourage them to begin having sex when they otherwise might not have involved themselves (Robab *et al.*, 2013 and; Avusabo *et al.*, 2008).

Society influences what people believe and how they feel about sexuality (SIECUS and National Guidelines Task Force, 2004). Sexuality education can be considered a complex intervention because it is an area involved with moral values, and it addresses the most sensitive aspects of human experience- sexuality (SIECUS, 2004). Teaching about sexuality to adolescents before marriage is acutely sensitive in many cultures (UNESCO, 2011; Avusabo *et al*, 2008; Amir *et al,* 2012).

It is true that many people including education ministries, teachers and parents may not be convinced of the need for sexuality education due to personal and/ or professional values (UNESCO, 2009; Padmini & Aggleton 2014). For instance, in Nigeria and India; sexuality education programmes came to a halt due to socio-cultural opposition thus, delayed implementation. Additionally, in Nigeria comprehensive sexuality education programme was reduced and all elements related to actual sexual and preventive behaviour including condom use and contraceptives removed (UNESCO and UNFPA, 2012).A collection of misguided concerns and beliefs that either sexuality education deprives children of their purity, leads to early sexual debut is responsible for this disagreement to implement sexuality education (Boonstra, 2011). This further means that existing generation of school children do not receive adequate information needed for healthy development thus, putting them at a disadvantage position (Amin *et al,* 2013).

In Uganda; traditional, social, economic and cultural norms encourages early marriage and child bearing at an early age (Sekiwunga and Whyte, 2009). Female adolescents in Uganda face cultural and social pressure from their families to marry young and begin child-bearing early. Additionally, child marriage and pregnancy are rooted in traditional and social norms because of low value attached to girls' education. Whereby, parents believe educating a girl is a waste of

time and resources when she is marriage material (Rubin *et al*, 2009 and; Sekiwunga and Whyte, 2009). The cultural rigidity is made real by the fact that adolescents lack knowledge and skills necessary to help them negotiate their way out.

Culturally in many regions in Uganda, parents do not talk about sexual matters with their children (Musiimenta, 2013; WHO, 1993). For instance in Buganda tradition, it is the paternal aunt (*Ssenga*) who talks to the girl, but not the parent. Even then, focus of the discussion is not on protection of the girl, but rather it is on how to please the man thus, leaving the girl susceptible to unsafe sex (Rassjo and Kiwanuka, 2010). Incorrect information about and access to sexual reproductive health services cripples adolescents ability to make informed choices, more so inability to discuss sexuality matters freely with parents and partners makes the situation bad (Rassjo and Kiwanuka, 2010; UNESCO, 2009; Boonstra, 2011).

According to Rassjo and Kiwanuka (2010), and Straight Talk Foundation (2013), tradition and lack of life skills further prevent adolescents to speak out and decide on if and when to have sex. They further showed that; generally people and especially adolescents living in the villages were found to have poor information about sexual and reproductive health rights. Where family planning is seen as inappropriate for adolescents who want to avoid pregnancy, because it is perceived to be used only by those who plan a family. In this case adolescent is seen as one who does not have a family to plan for, thus, exposing adolescents to unsafe sex as they are denied the protection.

2.3 Benefits of sexuality education in schools

Until recently, there was a great divide in the teen pregnancy prevention arena with one group maintaining that “abstinence-only education” programmes are the best and healthiest strategy to

prevent unintended teen pregnancies and sexually transmitted infections among teenagers. The other group claims a comprehensive approach to sex education provides today's youth with the information and decision-making skills needed to make realistic, practical decisions about whether to engage in sexual activities (UNFPA, 2015; UNESCO, 2009). They contend that such an approach allows young people to make informed decisions regarding abstinence, gives them the information they need to set relationship limits and to resist peer pressure, and also provides them with information on the use of contraceptives and the prevention of sexually transmitted diseases (WHO, 2011; Stanger *et al,* 2011).

Comprehensive sex education proponents argue that by denying teens the full range of information regarding human sexuality, abstinence-only education fails to provide young people with the information they need to protect their health and well-being (Stanger et al, 2011; Kirby 2001). Information is the key element in addressing the pandemic of teenage pregnancy (Kirby, 2001). Surveys of young people found that students who have sex education, know more and feel better prepared to handle different situations and decisions than those who are not exposed to information (Henry, 2000). Even if they have not encountered such situation, it is a right issue and promotes skills development to avoid risky behaviour (UNFPA, 2015).

Abstinence education interventions promote abstinence from sexual activity (either delayed initiation or abstinence until marriage) and mention condoms or other birth control methods only to highlight their failure rates, if at all (Advocates for Youth 2009). Abstinence only education is based on the more morally conservative approaches led by the conservative Christian crusaders in the US in the 1960s (Kantor *et al,* 2008).These interventions generally include messages about the psychological and health benefits of abstinence as well as the harms of sexual activity. Abstinence-only proponents point to studies concluding that the abstinence-only education

message has played a central role in the decline of adolescent sexual activity, and related negative health outcomes, over the last decade (Kirby 2008). However, recent studies have reported that abstinence only education is ineffective in delaying sexual debut or risky sexual behaviours (Kirby, 2002; Stanger et al, 2011)

One study by Jones, Toffler and Mohn (1999) reported that abstinence and decreased sexual activity among sexually active adolescents are primarily responsible for the decline during the 1990s in adolescent pregnancy, birth and abortion rates in the US. Attributing these declines to increased contraception is not supported by the data. Kirby (2002) evaluates the validity of 10 studies providing proof that abstinence programmes reduced early sexual activity. Nine out of 10 studies fail to provide credible evidence and one study shows some delay, but only among specific age groups. Currently, there is no existing strong abstinence-only programme with strong evidence that they either delay sex or reduce teenage pregnancy.

According to Human Rights Watch (2005), Uganda is redirecting its HIV prevention strategy indirectly targeting teenage pregnancy for young people towards focusing primarily on promoting sexual abstinence until marriage. The strategy is endorsed by powerful religious and political leaders in Uganda, but the shift is composed and funded by the US government who has taken the same stance by giving more funding to abstinence-only programmes. There was no funding for comprehensive sexuality education which emphasizes abstinence, but also provides information about contraception and condoms (Lindberg 2011). Without technical and financial support, implementation of comprehensive sexuality education may remain a challenge in Uganda.

Morron, Myer, Mlobeli, Gutin and Grimsrud (2007), feel that it stands to reason that this new direction is to replace existing, sound public health strategies with unproven and potentially life-threatening messages, impeding the realization of the human right to information, to the highest attainable standard of health, and to life. Moron et al (2007), revealed abstinence-only strategy in Uganda fails to offer young people information on condoms and safer sex, but additionally promotes marriage while withholding information on its inherent risks. Morron *et al.* (2007) argued that evidence base suggesting that AIDS reductions are due mainly to abstinence-only – discredits this argument (ABC strategy – Abstain, Be faithful, use a Condom – not even known in Uganda until 2002). A study of the 'Postponing Sexual Involvement' curriculum in California found that its students were more likely to report becoming pregnant or causing pregnancy although it was unlikely that the Postponing Sexual Involvement programme was the cause. The programme showed no measurable impact on initiation of sex, frequency of sexual activity and number of sexual partners (Collins, Alagiri & Summers, 2002).

Evidenced from studies conducted have shown that unwanted pregnancy among adolescents drops significantly when adolescents are given age appropriate and accurate information regarding sexuality (WHO, 2011). Limited access to accurate sexuality education information contributes to sexual health problems such as unwanted pregnancies and STIs, which are still common all over the world including, Uganda (Kurth *et al*, 2010). UNESCO (2009) noted that 10% of births worldwide are to teenage mothers with higher rates of maternal mortality than older women. Research indicates that, such problems are affecting Uganda even more owed to scarce resources (Rutaremwa, 2013). Stephenson *et al* (2014) and Elshibly and Schmalisch (2008) noted that nearly 60% of young women and 45% of young men in Sub-Saharan Africa

have had sex before the age of 18 years, thus exposed to unplanned pregnancy, STIs and other associated problems.

Research has shown that sexuality education leads to delayed and more responsible sexual behaviour (UNESCO, 2009). All children are entitled to access to right information that is scientifically accurate, non-judgmental, age appropriate and complete. If this is hidden from children, they will receive conflicting and damaging messages from peers and the media. It is therefore clear that good sexuality education balances this through by providing correct information and having emphasis put on values

2.4 Conclusion

Reviewed literature shows that the mode of teaching sexuality education has been highly challenging in many countries including Uganda in the last few decades, with contentious argument regarding its purpose. Literature further pointed out existence of misunderstandings among people about the nature, purpose and effects of sexuality education because of cultural beliefs and perception in many communities. Despite clear and pressing need for school-based sexuality education, it is not available in most schools in Uganda and even factors for effective implementation are unclear. Furthermore, there are controversies on what topics can be discussed with adolescents. Even though, the bulk of literature points to the need for comprehensive sexuality education in preventing risky behaviours among adolescents, however, less is discussed on the process of effective implementation meaning, there are gaps that still need exploration, including, how effectively sexuality education is being delivered.

Culturally, in most African countries sexuality education is considered a highly sensitive issue and this affects the delivery of the message especially in situation where by some teachers feel

uncomfortable to teach sensitive topics. Literature fairly showed that cultural practices such as early marriage contribute to adolescent pregnancy. However, a lot could still be explored on how this cultural perception relates to sexuality education and the consequent adolescent pregnancies in particularly, Bugiri district under study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the procedures the researcher used to arrive at the findings. It focuses on Research Design, Area and Population of the study, Sample size and Sample selection techniques, Sources of data, Data collection instruments, Data quality, Measurement of study variables, Data analysis and Interpretation, procedure of the study and the limitations of the study and solutions. The study critically examined the implementation of school based sexuality education in primary schools in Bugiri District.

3.1 Research Design

The study employed a cross-sectional study design which was descriptive in nature. A cross-sectional design was preferred because it helped the researcher to collect required data at a particular time. A cross section of primary school teachers in Bugiri District, pupils, District technical officers including District Education Officer, Senior Probation and Social Welfare officer and Civil society staff as key informants were used to examine the mode of teaching, the nature of sexuality education provided, and the factors influencing school based sexuality education in primary schools in Bugiri District. The design was preferred because it facilitated use of tools to collect the required data at a specific point in time and was also cost effective for the researcher.

The study employed both quantitative and qualitative approaches. Quantitative approach was used to quantify incidences in order to describe current mode of teaching and nature of sexuality education in primary schools in Bugiri district. While qualitative approach was used to obtain

deeper understanding of factors influencing the practice of sexuality education practice in primary schools in Bugiri district.

3.2 Area of Study

This study was carried out in Bugiri district. The district is located in the South Eastern part of Uganda. The district along its boarders are Tororo to the northeast, Iganga to the west, Namutumba to the North West, Mayuge to the southwest and Busia to the south east. The district also extends to the Uganda/Kenya border in the south east and in the waters of Uganda/ Tanzania border in the South.

Bugiri is among the districts with the highest rate of teenage pregnancy at 30.6% (UBOS, 2014). Most of these adolescents are found in primary schools. Effective implementation of sexuality education would probably equip these adolescents with knowledge about sexuality and further prevent them from becoming pregnant and as well prevent them from contracting sexually transmitted diseases.

3.3 Study Population

Study population comprised of the pupils from primary Six to primary seven of Bugiri district, all the primary school teachers who have at least engaged in teaching sexuality education in one way or the other within primary schools for a period of at least not less than two years. Staff from the District Education department including the District Education Officer; Community Based Services department including District Probation and Social welfare officer and Community Development officer; Civil Society Organizations (CSOs) programme staff particularly from Straight talk, and SEPSPEL, were interviewed to obtain in-depth understanding

of sexuality education practice and establish how they support the curriculum. The population was selected because of their relevance to the study in terms of the investigations involved.

3.4 Sampling Procedures

3.4.1 Sample size

For the quantitative method, the sample size of this study was determined by a standard formula as used by Fisher *et al* (1998).

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

Where

n = Sample size;

Z = Standard normal deviation at 95% confidence level (1.96);

P = Proportion of target population estimated to be benefiting from effective implementation of sexuality education curriculum in primary schools (0.85);

q = I – p (0.15);

d = degree of accuracy set at 0.05; and

D = design effect (1)

Therefore $n = \frac{Z^2 pqD}{d^2} = \frac{1.96^2 * 0.15 * 0.85 * 1}{0.05^2} = 196$

The target population of teachers in primary schools in Bugiri district is 2,766 (EMIS, 2009). Therefore the final sample size was computed: -

$$N = n_1$$

$$n = \frac{n}{\left[1 + \left(\frac{n}{N}\right)\right]}$$

Where

n_1 = the desired sample size when population is less than 10,000

n = desired sample size when the population is more than 10,000

N = estimate of the population (2,766 total number of teachers in Bugiri)

Therefore;

$$n = \frac{196}{1+\left(\frac{196}{2766}\right)} = 173$$

3.4.2 Sampling Techniques

The study employed two sampling techniques of random and purposive. The sampling of four sub counties out of eleven was randomly selected. In each sub county, one parish was also randomly selected. Simple random sampling was used to select pupils of primary six and seven and purposive sampling technique was used to (specifically select teachers who have engaged in sexuality education programmes for at least 2 years) select teachers who engage in teaching about sexuality across all the primary schools in each parish. Teachers were purposively selected because they were believed to have the right information about the study.

From the population of 2766 teachers, a total of 151 teachers were given self- administered questionnaires. The teachers were issued questionnaire and they were requested to fill in the questionnaires, which were collected later by the researcher. A total of four FGDS were carried each consisting of between 8-10 pupils. Key informants were from the District Education department and CSOs in the District.

3.5 Data Collection Methods and Instruments

3.5.1 Data Collection Methods

The purpose of data collection is to generate data of outstanding quality (Polit and Beck, 2010). In this study, data was collected from both primary and secondary sources. Self-administered questionnaires with teacher, focus group discussions with pupils and key informant interviews were used to collect primary data. Information on secondary data was gathered from reviewing literature on the subject matter.

3.5.2 Data Collection Instruments

Nature of sexuality education program available to pupils, factors influencing the nature of sexuality education programmes and the mode of teaching sexuality education programmes were collected by administering questionnaires to 151 teachers teaching sexuality education in primary schools. On the other hand, key informant interview guide was used to collect more on factors influencing the nature of sexuality education programmes from Officials from the Department of Education at the District. Focus group discussion guide was used to collect information on the nature of sexuality education program available from pupils of primary six and seven to evaluate levels of knowledge and attitudes acquired through sexuality education. A documentary review guide was used to gather secondary information.

3.6 Quality Control Methods

Quality control was ensured using two methods that is; validating the research tools and testing for reliability of the tools to collect the actual data required.

3.6.1 Validity

Relevant instruments were used to gather information to ensure validity. The questionnaires were subjected to the scrutiny of the supervisors and their recommendations were used to finally formulate instruments that had the ability to obtain the expected relevant data.

$$\text{Average of CVI} = \frac{\text{No of items rated valid}}{\text{All items in the questionnaires}}$$

The CVI for teacher questionnaires was 0.75 the recommended validity (Amin, 2005). Hence, the questionnaires were considered valid for data collection.

3.6.2 Reliability

To ensure reliability, the instrument was thoroughly edited and pre-tested outside the study area. The questionnaire was pre-tested in two selected schools outside the study area that ensured reliability. It helped to ensure consistency and dependability of the research instruments and their ability to collect data that answered to the objectives of the study. Raw data from the instruments were subjected to a reliability analysis from which Cronbach's co-efficient alpha was systematically and consistently computed using the following formula Statistical Package for Social Scientists (SPSS 16). The reliability for the questionnaires for teachers was 0.83 which is greater than 0.7 the recommended reliability (Amin, 2005).

3.7 Data Analysis

Data was collected, cleaned, coded and analysed using Statistical Package for Social Sciences (SPSS 16). Quantitative data was analysed using descriptive statistics. Descriptive statistics included frequency distribution means and percentages. Data was presented using frequency distribution tables' percentages, and graphs.

Thematic and content analysis approaches were also extensively utilized in data categorization and further analysis for qualitative data. The researcher summarized the data into themes and sub themes basing on research specific objectives and key themes. This analysis was used to present the data in a more verbatim form, quotations from study participants were recorded verbatim so that the researcher can come up with clear and yet meaningful findings.

3.8 Ethical Considerations

The research proposal was presented to the supervisor and Faculty of Health Sciences for approval before the researcher proceeded with field work. The ethical standards of ethical conduct of research of Beneficence, Respect for human dignity, and Justice were upheld as recommended by Polit *et al* (2010). Efforts were made to ensure that the environment was enabling for the discussions and confidentiality was emphasized throughout the process.

The respect for human rights of participants was taken into considerations. This involved the right to self- determination and the right to full closure, which are the major elements of an informed consent. Participants were independent, and able to control their own activities. The researcher informed participants of their voluntary action to participate in the study and that they were free to withdraw or not to respond to any questions without being punished.

The principle of justice involves participants' rights to fair treatment and privacy. The selection of participants was based on the research requirements and not the vulnerability position of certain people. No unnecessary promise was made to participants. Consent was obtained from all participants and for the adolescents; in addition to their consent, their parents/caregivers were contacted to ensure there is informed consent. The researcher upheld the principles of working

with children throughout the research given the fact that most of the primary school pupils were below 18 years of age.

CHAPTER FOUR

PRESENTATION AND INTERPRETATION OF STUDY FINDNIGS

4.0 Introduction

This chapter presents and interprets study findings. The analysis is guided by the specific objectives and research questions that were set in the study. It gives the description of the back ground, description of the dependent variable and ends with the achievement of the respective objectives.

4.1 Nature of respondents for the study

Both boys and girls of primary six and seven aged 13 years and above and all the primary school teachers who are involved in sexuality education practice were involved in the study.

Table 4.1: Distribution of teachers and pupils by gender

Category	**Gender**		**Total**
	Males	**Females**	
Pupils	21(52.5%)	19(47.5%)	**40(20.9%)**
Teachers	39(25.8%)	112(74.2%)	**151(79.1%)**
Total	**60(31.4%)**	**131(68.6%)**	**191(100.0%)**

Source: ***Field data***

Table 4.1 above illustrates that the male pupils had the highest representation of about 53% compared to the female pupils between 13 – 14 years and in primary seven. Majority of the teachers who engage in teaching sexuality lessons were females (74%) compared to males (26%). Information about background characteristics of teachers teaching sexuality education included the age, academic qualification and years they had spent teaching sexuality education and the results are presented in table 4.2 below.

Table 4.2: Background characteristics of teachers

Variables	Frequency	Percent (%)
Age		
20-25	6	4.0
26-30	7	4.6
31-35	10	6.6
36-40	50	33.1
41-45	51	33.8
Above 45	27	17.9
Academic qualification		
Certificate	96	63.6
Diploma	49	32.0
Degree	6	4.0
Years spent teaching sexuality education		
Less than a year	7	4.64
1-2 years	27	17.88
3-4 years	49	32.45
5-6 years	21	13.91
Above 6 years	47	31.13

Source: ***Field data***

Statistics from Table 4.2 above also showed that the biggest number of these teachers were above 40 years of age and had permanent jobs. Despite the fact that majority of these teachers were only certificate holders, they had spent not less than 3 years teaching sexuality education. Most teachers reported to have taught sexuality lessons between 3-4 years within primary schools.

4.2 Nature of sexuality education program available to pupils

When teachers were asked to state whether their school deliver sexuality education, all the teachers (100.0%) revealed that they have sexuality education programmes in their schools. They further mentioned the nature of sexuality education that they deliver to the pupils and details are presented in Table 4.3 below.

Table 4.3: Nature of Sexuality Education

Category of Sexuality Education	Frequency	Percent (%)
Abstinence only until marriage	32	21.2
Comprehensive sexuality education	119	78.8
Total	**151**	**100.0**

Source: ***Field data***

From Table 4.3 above, majority (78.8%) of the teacher respondents revealed that they deliver comprehensive sexuality education which included abstinence as a way of changing the sexual behaviour of the pupils and also shared with learners medically accurate, age-appropriate information and instruction about condom use and other forms of contraception, values, attitude and skills, human development, sexual behaviour. Only 21.2% delivered abstinence only until marriage which stressed that abstinence is the only choice outside the context of a heterosexual marriage. In this category, medically accurate information about condom use and other forms of contraception was not included. No teacher mentioned that they deliver abstinence only to the pupils.

Table 4.4: Information delivered in sexuality education programmes

Information delivered	To a big extent	To a small extent	Not at all	Mean	Standard deviation
Human development	132(87.4%)	19(12.6%)	0(0.0%)	1.126	0.333
Sexually transmitted diseases	114(75.5%)	29(19.2%)	8(5.3%)	1.230	0.563
Teen pregnancy	133(88.1%)	18(11.9%)	0(0.0%)	1.119	0.325
Abortion	0(0.0)	38(25.2%)	113(74.8%)	2.748	0.435
HIV and AIDS	147(97.4%)	4(2.6%)	0(0.0%)	1.026	0.161
Condoms use	14(9.3%)	39(25.8%)	98(64.9%)	2.556	0.660
Drug abuse	146(96.7%)	5(3.3%)	0(0.0%)	1.033	0.180
Sexual behaviour	32(21.2%)	92(60.9%)	27(17.9%)	1.967	0.626
Contraceptives use	11(7.3%)	87(57.6%)	53(35.1%)	2.278	0.591

Source: ***Field data***

Table 4.4 suggests that the most delivered information was on HIV/AIDS, followed by drug abuse, and third was teen pregnancy. The least information disseminated to Pupils was on contraceptive use. Considering the means reflected 1.126 and 1.230, the information delivered in sexuality education programmes includes as well human development and sexually transmitted diseases respectively.

From FGDs, pupils stated the topics taught in schools, which included; what is pregnancy, causes of pregnancy and the preventive measures among others. The main preventive measures the pupils highlighted included abstinence as narrated by one of the pupils during the focused group discussion;

> *"In this health education, our teachers have taught us the importance to stay safe from early sex if we want to finish our education. We know the benefits to stay away from sex and not land us ourselves into unwanted pregnancy, but we have also come to know and*

> *accept that menstruation is a normal body change. The boys no longer mock at us but rather they have become supportive".*

The result from the interviews conducted with key informants also indicated that HIV/AIDS, human development, sexuality transmitted diseases, and teenage pregnancy were the topics taught and contraceptive use was not always talked about. One of the key informant respondent had this to say;

> *"The teachers cannot talk about sex but they can talk about body organs. They do not talk about condom and contraceptive use with children as this is not something to discuss with children, and the teachers are not supposed to do this. The most important thing for them to do is to educate these children on abstaining and wait until they complete their studies then they can know more about this. We have come to realise that some teachers are talking about condom and family planning methods, this is not appropriate for the children and they need to remove this and only talk about age appropriate information".*

This study finding pointed out that some stakeholders support abstinence only education and considers any information about condom and contraceptive use as not being appropriate to talk about with school pupils. The reasons given were that such teaching robes children of their innocence, is against the religious belief, and culturally not sensible. This finding means that there is still misinformation on sexuality education and consequently many pupils in Bugiri are not accessing information on condom, and contraception use, abortion, and sexual behaviour, leaving them potentially vulnerable to risky sexual behaviour.

Table 4.5: How sexuality education is taught in schools

How sexuality education is taught	Frequency	Percent (%)
Not decided	2	1.3
Integrated in other subjects and delivered as lessons through lecturing by teachers, discussions and exercises	109	72.2
Taught during Co-curricular activities (school clubs such as life skill club, health club, MDD club, and child rights club)	40	26.5
Total	**151**	**100.0**

Source: ***Field data***

Results in Table 4.5 above indicates that sexuality education lessons were integrated in other subjects as reported by 72.2% of the respondents, followed by 26.5% who revealed that they are taught during co-curricular activities. Only 1.3% of the respondents mentioned that they were not decided on a systematic way of teaching sexuality education.

One of the key informant respondent said;

> *"In our school teaching of sexuality education is not streamlined, every teacher has his/her own style of teaching. Others integrate it in other subjects like science and others choose to teach it during co-curricular activities. Depending what you find to be easy and not time wasting"*

Majority of the teachers indicated that sexuality education was combined with other subjects like science, health education and delivered as lessons through lecturing, discussion, and exercise. In this teachers took active roles to teach pupils on sexuality topics. On the other hand a small percentage used co- curricular activities to teach sexuality education. These co-curricular activities included activities within the different school clubs like life skills group, Girl child

rights club, health club, music drama and dance club. In these clubs the pupils were guided by the teachers who are patrons on these clubs, each theme for discussion would be identified and the group would hold discussions around the identified topic. Some respondent mentioned that the civil society groups like Straight talk, and SEPSPEL who are working in the districts were coming in to facilitate school club activities and training teachers on sexuality and life skills education. During the interviews with a key informant, one of them said;

> "*The method of teaching sexuality education in primary schools in this district vary from school to school, some schools are using the whole school approach where all stakeholders are involved and others are not using this. It also depends on the interest of the teachers and most importantly the head teacher. In some school, we distributed CDs, Television screen, and computers to support teaching sexuality education but this method is not being used as most schools do not have electricity and cannot use these equipment"*.

Some teachers were undecided on the method being used to teach sexuality education and this could be as a result of unclear guidance on the specific and effective way to deliver this education in a way that will empower the pupils to make healthy choices.

4.3 Factors influencing the nature of sexuality education programmes

The factors influencing the nature of sexuality education programmes included teacher training on sexuality education, sources of information on sexuality education, time allocation, teaching approaches, parental attitude and cultural barriers.

4.3.1 Teachers' special training on sexuality education and knowledge adequacy

Table 4.6: Relationship between teachers' special training and adequate knowledge

	Knowledge adequacy		**Total**
Teachers Specially Trained in Sexuality Education	**Yes**	**No**	
Yes	41 (71.9%)	16 (28.1%)	57(100.0%)
No	57 (60.6%)	37 (39.4%)	94(100.0%)
Total	**96 (64.9%)**	**55 (35.1%)**	**151(100.0)**

Source: ***Field data***

From Table 4.6 above, out of the 57 teachers who had trained on sexuality education, 71.9% of them had adequate knowledge on the subject while only 28.1% had inadequate knowledge. The findings that teachers who were specially trained on sexuality education had adequate knowledge on sexuality education compared well with findings of a study carried out in India on sounds of silence in teaching sexuality education by Boler and Carrol (2004) that 54% of teachers interviewed who reported having adequate knowledge on sexuality education had attended a training course on sexuality education.

The findings that teachers without any training on sexuality education felt inadequate agrees with findings of a study carried out in Kenya and India on obstacles on teaching sexuality education (Boler, 2003). The study showed that 45% of Kenyan teachers did not have adequate knowledge to teach sexuality education compared to 20% of Indian teachers. Majority of teachers in both countries reported never having been on a training course on sexuality education, 70% in India and 54% in Kenya (Boler, 2003). Another study conducted by UNESCO (2008) on teachers training on sexuality education in Eastern and Western African countries showed that little or no

time or resources are being devoted to sexuality education in pre service or in-service training of teachers.

It was evident that knowledge of the teachers on sexuality education influenced the effective implementation of sexuality education programmes in primary schools in Bugiri District, as one of the key informants narrated;

> *"Most teachers feel incapable, unable to help and not confident to pass information concerning sexuality to pupils because they are not equipped enough to deal with the situation. HIV is a killer disease which has claimed so many lives of the young people and it's still claiming. The disease is spreading to the young generation yet we can do something about it. Teachers hands are tied because of lack of knowledge on sexuality education program"*

It was also revealed that teachers who had obtained special training on sexuality education did not encounter any problem in teaching the pupils sexuality education related lessons. The trainings of teachers were mainly organised and facilitated by civil society organizations working in the district as explained by one of the key informant respondent;

> *"The primary school teachers were selected and trained as patrons and master trainers. This training would take one week and sometimes two weeks. This trainings are about providing knowledge, skills and it emphasised facilitation skills not teaching as children need to be guided. Not only the teachers have an opportunity to attend this training, the trained teachers are supposed to provide in school training to the rest of the teachers in school".*

It is therefore evident that teachers who reported having inadequate knowledge on sexuality education could be those who did not benefit from these trainings as not all teachers have an opportunity to attend comprehensive training in sexuality education to enable them develop skills, knowledge, and confident to teach pupils in a useful way that facilitate skill building and empowerment. It was found that much as the trained teachers were supposed to conduct in school training for the rest of the teachers, this was not adequately done due to a number of reasons including lack of expertise in the subject matter, limited resources materials and time. This therefore affected the knowledge adequacy of teachers who did not attend the full training on sexuality education.

4.3.2 Source of information and knowledge adequacy

Not all the teachers teaching sexuality education were trained, and the teachers were asked on where else they obtain information that they used to train pupils. Teachers mentioned the different sources of information which included; literature materials like manuals, handouts, and text books, media, Internet and friends. It was found out that the teachers who obtained sexuality education information through literature material and the media felt that they had adequate knowledge in sexuality education program. However, literature also repeatedly points to the teachers who accessed information on sexuality education from literature to have adequate knowledge for example findings of a study carried out in Uganda that lack of sexuality knowledge among teachers was due to limited sources such as literature (Educational International, 2006).

However, there is no single source of information, which is adequate on its own. Another study in China by Hsia *et al (*2008) also found that there is no one source of sexuality information that was adequate in itself. The more sources of information such as through media, seminars, workshops, and health institutions a teacher accessed the more adequate a teacher was likely to

feel on sexuality information. Teachers went on to note that source of information influenced the usefulness and appropriateness of sexuality education programmes delivered in primary schools in Bugiri district, as one of the key informant narrated;

> *"Teachers were given teachers' guide, text books, and CDs which has really improved their knowledge and confidence in teaching sexuality education. They usually revise the teacher's guide as they prepare to teach sexuality education lessons, and sometimes they use learning materials and posters given to them".*

From focus group discussions, it was observed that pupils had wide knowledge on causes of pregnancy, having acquired this knowledge from school, their friends, and media and from newspapers. A very small number of pupils indicated that they had acquired knowledge on what causes pregnancy from parents or their siblings. This is could be explained by the view that sexuality education is considered culturally inappropriate in many families and therefore not discussed with children.

4.3.3 Time Allocated in teachers' time table for effective teaching of sexuality education

From the teachers' perspective, time allocation for specific sexuality education topics between 10-40 minutes was adequate. This was however a perspective of the minority (23.8%). Many preferred that time above 40 minutes would be more adequate (76.2%). It was clear that the attention given to sexuality education is not enough as seen by the inadequate time allocated it. However, the teachers quoted that sexuality education program is important in fighting early childhood pregnancy as well reduce on the dropout rate especially for the girl child and there is need for more time to be given to it to realize change in behaviour, gain more knowledge, perception and attitude change.

On a similar question with the key informants, one of the key informant respondent noted that;

> *"It is unfortunate that this type of education is not given the attention it deserves. Sexuality education is a big thing that every child should be able to benefit from. It should be packaged to suit all children to become self-aware and develop skills to protect themselves. This requires a lot of time, attention and making it part of school routine. But this is not the case, there is no structured way of teaching this subject and as a result, the teachers just use the little time they have to slot in some topics. This should change if we want to help these children".*

Similarly, in the focus group discussion with pupils, they indicated that the time used for sexuality education was not enough as usually they go for club activities in the evening at 4:30pm and they are required to do so many things within this little time. Although, there were some lessons combined with other school subjects like science and taught during class time, the pupils also felt that this time was inadequate and the teachers usually rush the topics to give more time to the other subjects examinable. During the FGD one of the pupils noted;

> *"I am grateful to our teacher for trying her best to teach us life skills, body changes, HIV/AIDS and how to prevent it. This information is very helpful, I used to be a stubborn boy, but this changed after me joining the life skills club were I learnt about self-awareness, my value as a child and setting future dreams. I also learnt about HIV/AIDS and how to prevent it through abstinence. However, she usually use very little time to discuss this with us in the group and this does not give us opportunity to ask questions. I would be happy if our head teacher can allow to give us more time to learn more about this so that instead of going at 4:30pm we should be starting early. Also instead of doing once in a while, we should be taught more regularly".*

From the study findings time allocation seemed to influence teaching of sexuality education where majority (76.2%) teachers felt time was not adequate. The results of the study agreed with a study carried out by Boler and Carroll (2004) on sounds of silence that teachers do not have enough time to teach about sexuality.

The respondents were to state whether they assess learners to evaluate if they acquired the necessary knowledge on sexuality education. Results indicated that majority of teachers 113 (74.8%) assess the learners, but 38 (25.2%) do not assess the pupils knowledge on sexuality education and this was also because of the limited time involved. In a FGD one of the pupils explained that;

> *"Each one of us has a book and whenever a session is facilitated, we are required to note what we've have learnt in our books and also come up with actions which we will implement. This book is exhibited termly to evaluate ourselves and see whether we are practicing what we have learnt, although sometimes we don't do this exhibition due to so many work that our teachers are involved in. Teachers also have a record book with specific records on each of us, these help teachers to monitor us individually."*

It was evident that time allocation on sexuality education influenced the effective implementation of sexuality education programmes in primary schools in Bugiri district, as one of the key informant further narrated;

> *"There is no adequate time allocated for sexuality education and there is a lot of interference as priority is given to other subjects and this has affected the completion of the curriculum. For instance teachers may plan to complete a module within a term, but they end up spending a year without completing. This makes it very difficult to really teach as expected for the desired change in behaviour"*

4.3.4 Teaching approach and challenges in delivering sexuality education related topics/ information

Teachers were asked about the challenges facing the practice of sexuality education in primary schools in Bugiri district and a number of factors where reported as problems hindering implementation. Among the many challenges raised was the issue of inadequate training in sexuality education. The teachers reported that there was no government training in this subject, but only a few teachers were trained by civil society organizations. The lack of training has serious implication on the quality of program delivered in terms of content and delivery methodology.

The respondents further stated that the big problem was the issue of misconception about sexuality education, that many people including religious leaders still have negative attitude against sexuality education and therefore discourage its implementation. On this misconception, one of the key informants had this to say;

> *"Before we started using the whole school approach, there was a lot of resistance about sexuality education. No one was positive about it including my fellow colleagues. Religious sector were very much against it and there is still no support from religious leaders. Some teachers still have their own attitude problems and do not teach some topics which they considers morally inappropriate especially condom use, abortion, and contraceptive use. Because of the misconception, we had to revised the manual that initially had 15 topics to only six big topics including HIV/AIDS, Gender, relationship value and attitude, culture and human rights, sexual reproductive health, and Human development. Even still some sessions under here are not taught because of this problem of misconception. The whole school approach has helped clarify things to parents and*

many parents in Bugiri are now getting interested and wanting their children to be taught. However, there is still a lot to work that needs to be done with all stakeholders."

Due to this misconception, the required support needed for successful implementation of sexuality education in schools is not provided. For sexuality education to be useful, it calls for support from all stakeholders with each playing effectively their roles in such a way that will enable the young people access to scientifically accurate and age appropriate information needed to gain skills, knowledge and ability to make informed decision and lead healthy life.

Additionally, limited access to tools, resources, and information on sexuality education was reported. The schools were supported by Civil Society Organizations working in the district to deliver sexuality education to pupils and the district does not allocate any funds to support sexuality education lessons. A few schools were given CDs, television screens to facilitate the lesson delivery. However, it was reported that these schools were not using it due to lack of electricity. It was therefore difficult for the teachers to educate learners effectively on sexuality education because of resource constraints. On the other hand it was noted that despite having resource materials, teachers without special training in sexuality education found it difficult to teach. Therefore, for effective teaching of sexuality education, teachers need to undergo special training on sexuality education and adequate resource materials should also be provided.

When teachers were further asked to state if the resource materials available were age-appropriate, out of the 24 (15.9%) who had adequate resource materials in their schools, only 6 (25.0%) respondents stated that indeed the resource materials were age-appropriate while 18 (75.0%) of teachers stated that the materials were not age appropriate. This means that the

current practice of sexuality education may not support pupils to develop skills needed to take control of their health issues.

The most popular method of teaching sexuality education was discussion method. This method was usually conducted during lessons and guided by a teacher. The teachers would introduce the topic, give facts about it then open discussions with pupils on the subject being taught. Majority 60.3% of the teachers used discussion method in teaching sexuality education. The study results revealed that teachers who used discussion method of teaching did not have problems in teaching sexuality education. The likely reason was that this method encouraged active learning through participation and skill development. Teachers were encouraged because students would ask questions among themselves then consult the teacher thus providing pupils an opportunity to understand the concept adequately.

It was also stated that 19.2% of the respondents used role-play method of teaching. It was observed that, 8 (27.6%) teachers who used role-play method of teaching had problems in teaching sexuality education. The reason for this was that, as the pupils assumed some role-play during sexuality education lesson the pupils would become shy, emotional and refused to participate in the lesson.

It was found out that only 10.6% of the teachers used enquiry method. It was also noted that 9 (56.3%) teachers who used enquiry method of teaching also had problems in teaching sexuality education. This was because this method where the teacher teaches by finding out what the learner know about the topic discourages full participation as some pupils became sensitive and suspicious of the intention. Further findings reveal that very few teachers 9.9% of the teachers used lecture method in teaching sexuality related education and none had problems in teaching

sexuality lessons. The findings of the study showed that teachers who used lecture method did not encounter problems teaching sexuality lessons. The reason for this was that those teachers who used this method, were not specially trained in sexuality education and just taught the subject from a factual and theoretical perspective thus making it easy for them to just disseminate the information they have. However, effective sexuality education requires the teacher to be a facilitator in the learning process and not just the lecturer.

The most popular method of teaching sexuality education was discussion method. A high number 91 (60.3%) of teachers used discussion method in teaching sexuality education. However, the study by Derebssa (2005) on innovative approaches of teaching and learning employed in primary school in Ethiopia found that most (88%) teachers still use lecture method in most classes. On the other hand 63% of teachers felt that interactive learning approach should be employed in teaching sexuality education to ensure learners connect sexuality issues with real life (Derebssa, 2005) thus, facilitating the process of knowledge and skills acquisition in the most logical way.

4.3.5 Teachers experience with Parental attitude and cultural barriers towards sexuality education

The teacher respondents were asked to state whether there has ever been a situation where a parent(s) feels their children should not be taught sexuality education. Majority of 106 (70.2%) teachers reported that parents had positive attitude in support of sexuality education, and this was attributed to the stakeholders' engagement and awareness creation activities conducted by civil society actors. Only 45 (29.8%) teachers mentioned that parents felt that their children should not be taught the subject. The major reasons for this were that some topics such as contraceptives, abortion, and sexual behaviour were considered to be not appropriate for pupils, spoiling

children, and are against religion and culture. This study finding concurred with Sawyer *et al.* (2008) who also found a substantial concern among parents in Palm Beach country schools, Florida regarding the current and future activities of their children and a high level of support for inclusion of specific sexuality topics in the school program. The study also indicated that the parents had a strong belief in the importance of providing skill instructions to avoid pregnancy, HIV and other STDs.

Teachers were asked to give their opinion on what should be considered to enable them teach sexuality education better. The responses included; Building the capacity for teachers through seminars and workshops, preparation of sexuality education syllabus. Most respondents indicated that provision of relevant teaching and learning resource materials such as videos and films was necessary. Other respondents felt that engaging resource persons like counsellors was important and that timetabling of sexuality education should be considered. Making sexuality education a concern for school inspection, and Integration of sexuality education into teacher training curriculum was further indicated.

Teachers were asked to state if they encounter problems while teaching sexuality education. Majority 70.9% of the respondents did not encounter problems in teaching sexuality education, while only 29.1% encountered problems. Hence, majority did not encounter problems in teaching sexuality education. Respondents who felt that they had inadequate knowledge pertaining sexuality education encountered problems teaching sexuality lessons. The more the teachers felt having adequate knowledge the fewer the problems they encountered. Emerging issues from the interview with key informants on factors that may influence children to engage in risky behaviour include poverty, media, and personal greed for fashionable clothes, parental neglect and lack of attention which pushes children to seek sexual attention.

4.4 Usefulness of the existing sexuality education programmes

To understand how useful and appropriate the existing sexuality education programmes are to the pupils, teachers were asked to the rate the teaching of Sexuality Education in their respective schools. Teachers and pupils further highlighted on the sexual awareness created by the program, sexual guidance offered by the program, as well as appropriateness of Sexuality Education Programmes in schools.

Table 4.7: Rating of the teaching of Sexuality Education

Problems	Frequency	Percent (%)
Good	13	8.6
Fair	21	13.9
Poor	117	77.5
Total	**151**	**100.0**

Source: ***Field data***

Teachers were asked to rate teaching of sexuality education in their respective schools based on the list of all the topics recommended by UNECSO in the 2009 guidelines on sexuality education on a scale of 1 to 3; 1 to mean poor, 2 to mean fair and 3 meaning teaching of sexuality education is good. The results from Table 4.7 indicated that majority 77.5% rated the teaching of sexuality education as poor, while 13.9% rated sexuality education as fair and the least 8.6% rated the subject as good. The major reasons given for the rating was that not all topics were taught, the time for implementation was inadequate with inadequate resource materials, the teachers were also not well trained to facilitate quality and objective discussions with pupils, and was mostly conducted in school with little support from parents.

Despite these ratings, most of the teachers and pupils were of the view that Sexuality Education is very important and however poor it is being implemented, it creates awareness by providing information to young people to influence behaviour change. The following verbal quotes reflected the above idea:

> *"I think teaching us about sexuality helps us to know how bad it is to engage in early sex and what the consequences of indulging in early sex are. Through this education I have been able to set my future dream and I am motivated to work hard and complete my education because I have more information than the rest of my friends who are not life skills club members".*

The above findings illustrate that sexuality education plays a vital role in helping children understand their value, discover their potentials, identify and set their future goals. This deep-down motivation appeared to be influencing pupils' behaviour and commitment towards education positively. In another Focussed Group Discussion one of the pupils had this to say;

> *"Participation in sexuality education activities have helped me to learn more about teenage pregnancy and how to prevent it. I have not been able to discuss this at home not because there is no one to talk to about this but I really don't feel comfortable talking about this at home. I feel finer to talk about this with my group members and our patron than with anyone at home".*

Sexuality education creates awareness by providing accurate and age appropriate information to young people. Research agree that sexuality education allows young people to make informed decisions regarding abstinence, gives them the information they need to set relationship limits and to resist peer pressure, and also provides them with information on the use of contraceptives

and the prevention of sexually transmitted diseases (WHO, 2011; Stanger *et al,* 2011). One of the pupils stated;

> *"Sexuality education is very good, it helps us to have knowledge that we cannot get from home. I have been able to learn so much about teenage pregnancy and its dangers through sexuality education lessons conducted".*

These findings has pointed that despite the challenges associated with the current delivery of sexuality education, it helping in awareness creation about issues of sexuality among pupils. The teachers further indicated that there is change in the number of sexual related problems reported in school. The teachers also reported that the self-esteem of pupils have improved as a result of attending sessions on self-awareness, values, and decision making. This is in line with Kirby's acknowledgement of the importance of psychosocial elements such as "knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy," and influencing them in a way that keeps young people healthy (Kirby 2007). Furthermore, Kirby argues that effective programmes happen in environments where youth feel comfortable participating and involve pupils in a variety of activities that honestly address the psychosocial elements involved in sexual decision making.

Additionally, majority of the teachers (72.9%) indicated that sexuality education program had to a big extent created sexual awareness among pupils in primary schools as shown by the reduced cases of pregnancy in their schools. This may be attributed to earlier findings that most information delivered to pupils in sexuality education program is about, teen pregnancy and sexually transmitted diseases, HIV/AIDS and Human development. The teachers who mentioned that sexuality education had created sexual awareness to a small extent accounted for 21.1% of

the respondents interviewed. Only 6.0% indicated that sexuality education program had not changed anything as far as sexual awareness is concerned.

Similarly, the majority of teachers (84.8%) indicated that sexuality education program had to a big extent offered guidance to pupils about teenage pregnancy in primary schools. This may be attributed to earlier findings that most information delivered in sexuality education program was teaching pupils about teenage pregnancy and sexuality transmitted diseases. This was in agreement with the findings of a study conducted by (UNESCO, 2009) that sexuality education leads to delayed and more responsible sexual behaviour. Good programmes use sound instructional methods that make students identify personally with the information (Kirby, 2007). Specifically, those effective programmes "Employed activities, instructional methods, and behavioural messages that were appropriate to the teens' culture, developmental age and sexual experience".

When asked to state if, the program has provisions for parents and their children to work together, majority (91.4%) of the teacher respondents agreed. Only 8.6% of the respondents revealed that there is no such arrangements in their program. On the involvement of parents, one of the key informants indicated that;

> *"In Bugiri, we have been promoting the use of whole school approach to teach sexuality education. This approach provides for the involvement of teachers, pupils, parents, school management committees, and district technical team to share a role in implementation. This approach has helped to demystify the belief that sexuality education is all about sex, but it is about being able to handle challenges of sexuality as it affects education and performance as well".*

When teachers were asked to state if, in their opinion, teaching of sexuality education was useful and appropriate in their schools, majority (66.9.1%) of the respondents disagreed that the teaching of sexuality education was appropriate in their schools while 33.1% stated the teaching of sexuality education was effective. Those who stated that sexuality education was not appropriate in their schools attributed that to lack of enough training for the teachers who are teaching the subject and not putting enough emphasis on the subject because it is not examinable. This is also supported by earlier findings where majority (77.5%) of the teachers rated the teaching of sexuality education as being poor in schools in Bugiri district.

In conclusion, the respondents were in their opinion, asked to comment on sexuality education in their respective schools. The results indicated clearly that the subject was being taught in their schools and that it was helpful in behaviour change through awareness creation, forming attitude and values, facilitating pupils to set future goals and building pupils' commitment towards these personal future goals. Although it was also revealed that sexuality education teaching was steal struggling due to a number of challenges including capacity gaps and misconception thus, limiting its appropriate implementation.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the discussion of the findings observed and inferred from the data presented in chapter four. It is presented in three parts. Part one deals with the discussion of the results in chapter four derived from both the inferential and demographic characteristics. Part two deals with the recommendations and conclusion and part three with suggestions for further research.

5.1 Discussion

The study objectives included; understanding the type of sexuality education program available to pupils in primary schools in Bugiri district, determining the factors influencing the type of sexuality education programmes in primary schools in Bugiri district, and assessing the usefulness of the existing sexuality education programmes in primary schools in Bugiri district.

5.1.1 Type of sexuality education program available to pupils in primary schools in Bugiri district

The research findings showed that the type of sexuality education available to pupils was comprehensive education program as per the curriculum they were using. This curriculum had all the recommended topics by UNESCO (2009) in its international guidelines on sexuality education, although it was clear that some teachers were not teaching all the topics and sessions stated in the curriculum. The Oregon Department of Education (2015), revealed that comprehensive education emphasizes abstinence as the most effective way to prevent sexual transmitted diseases and early sexual practices. It however does not exclude medically accurate,

age-appropriate information and instruction about condom use and other forms of contraception values, attitude and skills, human development, sexual behaviour. Knowledge about these topics is a key risk/protective factor for sexual behaviour and health outcomes for primary school pupils. Therefore, the way the information is delivered to the pupils who majority are in the age bracket of 13-14 years is of paramount importance.

The findings pointed out the most delivered information to pupils was on sexually transmitted diseases and there preventive measure, drug abuse and early sexual practices but in some schools the approaches were, to differing degrees, essentially focused on abstinence-only as the main preventive measure, rather than devoting resources and classroom time towards approaches that are more effective and contain accurate and complete information. This approach limits sexuality education by not providing information about how young people can protect themselves from early adolescent if and when they do chose to have sex (UNAIDS/WHO 2008). To help pupils identify with that information, various methods have been employed to effectively deliver sexuality related information like the use of edutainment for example drama and shows, integration of sexuality program into other subjects and in co-curricular activities can be of benefit. However, teaching of sexuality education is not streamlined; every teacher has his or her own style of teaching. The researcher noted to attain the sexuality education learning objectives, all primary schools should adopt the international guidelines on sexuality education developed by UNESCO (2009) which specifies topics under which learning objectives have been defined and organized following six key concepts including; Relationships, Values, attitudes and skills, Culture, society and law, Human development, Sexual behaviour, Sexual and reproductive health.

It is clear that the current nature of sexuality education being delivered needs to be improved to allow a more comprehensive approach on the subject. It was clear that not all teachers were

covering all the topics stated in the curriculum, and more so not all topics were being covered. This means that these young people are not acquiring complete information needed to empower them with skills, knowledge and ability to make informed decisions on issues of sexuality. This is against what UNFPA (2015) is advocating for, sexuality is a right and empowerment issues and therefore needs to be given the attention it deserves. If the young people do not receive the necessary preparation while still young, it will cause a health burden in the future. Yet, all these can be avoided by equipping young people with relevant comprehensive information on sexuality.

5.1.2 Factors influencing the nature of sexuality education programmes

Despite the benefits from teaching sexuality education in primary schools, several factors undermined the nature of sexuality education programmes for teenagers in Bugiri district. One of the most important challenges is lack of teacher training on sexuality. The study findings indicated that teacher training on sexuality was one of the factors influencing the nature of sexuality education programmes including the content delivery. Teacher training is fundamental to the successful delivery of sexuality education in schools. Yet, efforts to train teachers are often inadequate, if in place at all. This is in line with the findings from the research study conducted by UNESCO (2008) in Malawi where teachers reported not receiving any training on sex education. Even then, the few occasions where training is conducted, little is done to follow up and monitor to ensure the training leads to the desired results, in most cases the training is unfortunately considered an end itself. According to a study conducted in Uganda by UNESCO, many teachers have opted not to teach sex education as a result of inadequate training (UNESCO, 2008). Teachers are not likely to have experience dealing with these issues in class,

and require specialized training so they are comfortable discussing them without letting personal values conflict with the health needs of the learners (UNESCO, 2009).

Teacher training as a fundamental way to the successful delivery of sexuality education is further supported by findings from a study carried out by Boler and Jellema (2005) on teacher training in Zambia that poorly trained teachers are often too shy to teach sexuality education. The study further concluded that such teachers also lack commitment to teach the topics in an often over-crowded curriculum. This therefore means that young people are not acquiring the right guidance and education they need on sexuality. This is because their teachers are ill prepared to facilitate all topics in way that promote knowledge acquisition to influence behaviour. Unless teachers received adequate training in sexuality education, nothing much may change and the quality of sexuality education will be compromised, consequently affecting the health and ability of young people to develop and realise the full potential. There is need for urgent attention to avert this.

Although several curricular are now available for implementing sexuality education programmes for young persons in Bugiri district, sexuality education is still not accessible to the majority of young persons who need it because of the limited time allocated for the subject. The bulk of sexuality education programmes implemented in primary schools still use the extra-curricular methods because sexuality education is not included in the curricular in primary schools. Similarly, teachers are aware of their responsibilities to deliver sexuality education to pupils but the challenges still lie in the support that they receive from parents as well as the cultural barriers. Evidence suggests that society influences what people believe and how they feel about sexuality (SIECUS and National Guidelines Task Force, 2004). This means that for effective delivery of sexuality education program in primary schools; parents, pupils, teachers, local

leaders and religious leaders need to work together with a common understanding on the purpose of sexuality education. Otherwise, if the collaborative power is not tapped, the difference in understanding will further influence sexuality education program in primary schools.

Musiimenta (2013), stresses that in many regions in Uganda parents do not talk about sexual matters with their children. Take for instance in Buganda tradition, it is the paternal aunt (*Ssenga*) who talks to the girl but not the parent. Even then, focus of the discussion is not on protection of the girl, but rather it is on how to please the man thus, leaving the girl susceptible to unsafe sex (Rassjo and Kiwanuka, 2010). Boonstra (2011) pointed out that incorrect information about and access to sexual reproductive health services cripples adolescents' ability to make informed choices, more so inability to discuss sexuality matters freely with parents and partners makes the situation bad. The misconception on sexuality education should become an advocacy issue to promote comprehensive sexuality education, which is the best as evidenced by many researchers (Kirby, 2007, Stanger et al, 2011; UNFPA, 2015). Comprehensive sexuality education holds a holistic view of sexuality and sexual behaviour. It is age-appropriate, curriculum-based education that aims to equip children and young people, according to their evolving capacities, with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality (UNFPA, 2015). This should be promoted in all schools so as to enable young people develop skills to take control of things that affect their lives.

5.1.3 Usefulness of the existing sexuality education programmes

The findings of the study indicated that teaching of sexuality education component of the curriculum in primary schools was poor (78%). The fact that sexuality education is not examinable seemed to have a bad influence on the weight the teachers gave the subject some opting to teach

other subjects instead. Some of the hindrances to usefulness and appropriateness of the sexuality education component of the curriculum were, majority of teachers lacked adequate knowledge on sexuality education, lack of adequate resources, minimal time allocated to teaching of sexuality education, tradition and lack of appropriate information about sexuality. All these challenges hinder pupils from accessing sexuality information which in turn may have helped them to make decision about early sexual practices. Consistent with Rassjo and Kiwanuka (2010) and Straight Talk Foundation (2013), adolescents living in the villages were found to have poor information about sexual and reproductive health rights, where family planning is seen as inappropriate for adolescents who want to avoid pregnancy, because it is perceived to be used only by those who plan a family, and in this case adolescent is seen as one who does not have a family to plan for, thus, exposing adolescents to unsafe sex.

One of the significant benefits of sexuality education is its positive effects on sexual behaviour of young persons. Sexuality Education creates awareness and guidance to pupils about teenage pregnancy in primary schools. This is in agreement with researchers including Stanger *et al.* (2011); Kirby (2007) and WHO (2011), who contend that sexuality education allows young people to make informed decisions regarding abstinence, gives them the information they need to set relationship limits and to resist peer pressure, and also provides them with information on the use of contraceptives and the prevention of sexually transmitted diseases (WHO, 2011; Stanger *et al,* 2011).

The findings also indicated that teaching of sexuality education was not appropriate in their schools as revealed by 66.9.1% of the teachers. Those who stated that sexuality education was not appropriate in their schools attributed that to lack of enough training for the teachers who are teaching the subject. This means that for sexuality education to become more useful to young

people, the facilitators should receive adequate training, they should have adequate resource materials, enough time balanced with delivery mechanisms.

5.2 Conclusions

Comprehensive sexuality education program is the main type of sexuality education delivered to pupils in primary schools in Bugiri district, as seen in the curriculum being used, although it was also reported that some teachers did not teach all topics, while other stakeholders felt that issue of condom and contraceptive should never be discussed with pupils. Yet, young persons are important resource for Uganda and thus, need sexuality education to enable them gain knowledge, build skill to influence positive behaviour change and responsible life choices. Research evidence confirms that sexuality education brings about positive behaviour change in young people and it is better if it is started early, maintained age appropriate depending on the evolving capacity of the child.

Unfortunately, access to sexuality education for young people is not yet universal in Uganda. The factors influencing the nature of sexuality education programmes manifests in the lack of adequate knowledge on sexuality education among teachers, limited resources and minimal time allocated for teaching sexuality education negatively influenced the implementation of sexuality education curriculum in primary schools. Determining the usefulness and appropriateness of the nature of sexuality education is a way to try and improve the current intervention of sexuality education offered in primary schools. The teachers agreed that sexuality education does provide awareness and guidance on sexuality, and equipping pupils with knowledge of a healthy sexual behaviour. For sexuality education in primary schools in Bugiri district to be useful to pupils, it should be conducted using a variety of teaching methods designed to involve the pupils and have them personalize the information. The teaching should further incorporate behavioural goals,

teaching methods, and materials that are appropriate to the age, and culture. All in all, it is important that sexuality education programmes should be scheduled in such a way that it can last a sufficient length of time to complete important activities adequately and should also effectively train teachers to adequately teach the subject.

5.3 Recommendations

To promote effective implementation of sexuality education that will influence behaviour change and promote responsible healthy choices among primary schools adolescents, this study recommends the following:

The Bugiri district and the primary should adopt and scale up the whole school approach of teaching sexuality education. The whole school approach was advanced by WHO in its concept of health promoting school, but not so many interventions have adopted this. Most interventions still work with selected stakeholders as found in many school, yet the whole school approach would bring everyone to the round table to discuss sexuality education as a whole. This approach could clarify on misconceptions about sexuality education, bring all important stakeholders together for an open and factual discussion, and build collaborative power needed for successful implementation.

Additionally, the teachers should adopt the use of more participatory method to teach sexuality education, the method that will keep the children engaged and taking active discussions. This will make the subject more meaningful to them as they will be able to ask questions which they find it difficult to ask when other methods are being used.

Furthermore, the peer to peer approach should also be adopted by schools. This will facilitate peer to peer experience sharing and asking questions which pupils cannot ask to their teachers.

However, for this to work well the peer educators should be taken through a thorough training to equip them with knowledge and skills to be able to facilitate peer discussions.

The Ministry of Education and Sports should mainstream the training of teachers to deliver sexuality education into teacher training curriculum to support all teachers to acquire adequate knowledge on sexuality education and effective facilitation skills. Additionally, the Ministry of Education and Sports should harmonize sexuality education curriculum and its implementation in primary schools as part of school syllabus, and should have it taken as an area which is assessed. Furthermore, the Ministry of Education should provide resource materials such as text books at every level of learning in schools so as to provide quality education.

An in-service course for teachers on sexuality education should be introduced at the teacher training colleges, with a view of training teachers who are already out there teaching. This could help improve the knowledge and confidence level of teachers to deliver sexuality education to pupils.

Bugiri district should develop clear mechanism and tools for monitoring implementation of sexuality education in schools to ensure quality age appropriate information are provided to all pupils systematically.

The issue of misconception around sexuality education should be taken up by district, and Civil Society Organizations as advocacy issues. Deliberate planned activities should be conducted with all stakeholders to inform and demystify the misconception around sexuality education.

5.4 Suggestions for Further Research

The study covered only one District. There is need to extend the study to other Districts in the country. This will help find the relationship or difference in factors affecting the practice of sexuality education programmes in different regions.

This study only covered primary schools in Bugiri district, the research may be replicated in the secondary schools in Uganda.

REFERENCES

Amin S., Austrian, A., Chau, M., Glazer, K., Green, E., Stewart, D., and Stoner, M., 2013. *Adolescent Girls Vulnerability Index: Guiding Strategic Investment in Uganda.* New York: Population Council.

Avusabo-Asare k, Bankole A, Kumi-kyereme A, 2008. *Views of adults on adolescent sexual and reproductive health: qualitative evidence from Ghana.* New York: Guttmacher Institute; 2008.

Bankole, A., Biddlecom, A., Guiella, G., Singh, S., & Zulu, E., 2007. Sexual Behaviour, Knowledge and Information sources of very young adolescents in four Sub–Saharan African countries. *African Journal of Reproductive Health* 11(3):28–43.

Bholah, R, and Gungaden, A., 2007. *A doorway to an innovative Teaching and learning Approaches. Sexuality education*. UNAIDS/WHO publication UK.

Blum, R.W. and Pilgrim, N.A, 2011. *Protective and Risk Factors Associated with Adolescent Sexual and Reproductive Health in the English-speaking Caribbean: A Literature Review*. Elsevier B.V. http://www.sciencedirect.com/science/article/pii/S1054139X11000917.

Boler, T., and Jellema, A. 2005. *A cross country study of education responses to Sexuality Education, Global Campaign for education.* International Education Unit, Action Aid

Boonstra, D. H., 2011. Advancing sexuality education in developing countries: Evidence and implications. *Guttmacher Policy Review*14 (3):17–23.

Derebssa, D. S., 2005. *Approaches in Ethiopia primary schools; Monitoring results of Education for all*. Addis Ababa: UNESCO.

Eisenberg M. E., Madsen N., Oliphant J. A, Sieving R. E, and Resnick M., 2010. Am I qualified? How do I know?" A Qualitative Study of Sexuality Educators' Training Experiences. *J Health Educ*. 41(6):337-344.

Elshibly A. M. and Schmalisch G., 2008. The effect of maternal anthropometric characteristics and social factors on gestational age and birth weight in Sudanese new born infants. *BMC Public Health*.

Erikson, Erik H., 1968. *Identity: Youth and Crisis.* New York: Norton.

Eva-Britta Rassjo, Robert Kiwanuka, 2010.*Views on social and cultural influence on sexuality and sexual health in groups of Ugandan adolescents.* Sexual and Reproductive Healthcare Volume 1, Issue 4, November 2010, Pages 157–162 doi:10.1016/j.srhc.2010.08.003.
8: 244.

Fonner, V., Armstrong, K., Kennedy, C., O'Reilly, K., and Sweat, M, 2014. School Based Sex Education and HIV Prevention in Low and Middle-Income Countries: A Systematic Review and Met-Analysis. I 9 (3).

Glenn Laverack, 2007. *Health Promotion Practice Building Empowered Communities*. Open University Press McGraw-Hill Education McGraw-Hill House Shoppenhangers Road aidenhead Berkshire England SL6 2QL. ISBN– 10: 0335 220 576 (pb)

Henry, J. Kaiser Family Foundation, 2000. Sex Education in America: A Series of National Surveys of Students, Parents, Teachers and Principals (Summary of Findings) [Internet]. September 2000. Available at: www.kff.org/content/2000/3048/SexED.pdf. Accessed July 16, 2015.

Hodzic A., Budesa J., Stulhofer A. and Irvine J, 2012. *The politics of youth sexuality: Civil society and school-based sex education in Croatia.* SAGE, DOI: 10.1177/1363460712439656 The online version of this article can be found at: http://sex.sagepub.com/content/15/3-4/494

Jacob, J.W., Mosman, S. S., Hite, J. S., Morisky, E. D., and Nsubuga, K. Y, 2007. Evaluating HIV/AIDS education programmes in Ugandan secondary schools. *Development in Practice* 17(1): 114–123.

Kantor, ML, Santelli, SJ, Teitler, J & Balmer, R, 2008. *Abstinence-only policies and programmes: An overview.* Sexuality Research and Social Policy 5:6–17.

Kirby D, 2002. The impact of schools and school programmes upon adolescent sexual behaviours. *J. Sex*. Res. 39(1):27–33.

Kirby D, 2000. What does the research say about sexuality education.*Educational Leadership*. 58, 72-76.

Kirby D, 2007. *Prevent Unplanned Pregnancy. National Campaign to Prevent Teen and Unplanned Pregnancy; 2007.Emerging Answers 2007.* London: Sage

Kurth, F., Belard, S., Mombo-Ngoma, G., Schuster, K., Adegnika, A. A., Bouyou-Akotet, M. K., Kremsner, P. G. and, Ramharter, M., 2010. *Adolescence as Risk Factor for Adverse Pregnancy Outcome in Central Africa - A Cross-Sectional Study.* Landom Myer. In http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3004789/

Moreno, M., Breuner, C. C. and Lozano, P., 2012. *Provocative Questions in Parochial Sex*

Education Classes: Higher Incidence in Younger Students. Adolescent Medicine; Department of Pediatrics, Child Health Institute, University of Washington, Seattle, Washington, USA. In Journal of pediatric and adolescent Gynecology. In http://www.sciencedirect.com/science/article

Morroni, C., Myer, L., Mlobeli, R., Gutin, S. & Grimsrud, A, 2007. Dual protection among South African women and men: perspaectives from HI care, family planning ans sexually transmitted infection services [clinics]. Available from engenderhealth.org/../southafricadualprotectionreo. Accessed on March, 23, 2015

National Task Force, 2004. Guidelines for Comprehensive Sexuality Education. 3rd Edition, Washington DC, Sexuality Information and Education Council of the United States, Pages; 13, 14, 18, 19, 20. In http://www.goole.com/url?sa=t&q=&esrc= s&source=web&cd=2&ved=0CC4QFjAB&url=http%3A%2F%2Fsexedu.org.tw%2Fguideline.pdf&ei=akKRVMaSC4XvUvzVgsAE&usg=AFQjCNFlGKXqreaL47cLsBczlN6bx5gFuA. Accessed on 8 November 2014 at 17:29

PATH, 2003. *Life Planning Skills: A Curriculum for Young People in Africa Uganda Version, Facilitator's manual*. Washington, D.C.: PATH (2003). In http/www.path.org

Patton, G. C., and Viner, R., 2007. *Pubertal transitions in health*. Lancet, published online March 27. DOI: 10.1016/S0140-6736(07)60366-3.

Padmini Lyer & Aggleton P, 2014. *Virginity is a virtue: Prevent early sex' – teacher perceptions of sex education in a Ugandan secondary school.* British Journal of Sociology of Education 35(3):432–448.

Polit, D. F., Beck, C.T., & Hungler, B. P., 2006. *Essentials of nursing research: Methods, appraisal and utilization*. (6th Ed.). Philadelphia: Lippincott Williams & Wilkins.

Rassjo E. R., and Kiwanuka R., 2010. *Views on social and cultural influence on sexuality and sexual health in groups of Ugandan adolescents*. Elsevier B.V. Sexual and Reproductive Healthcare Journal. In www.srhcjournal.org. Accessed on 5th November, 2014 at 10:00 hours.

Robab Latifnejad Roudsari, Mojgan Javadnoori, Marzieh HasanpourSeyyed Mohammad Mehdi Hazavehei, Ali Taghipour, 2013. *Socio-cultural challenges to sexual health education for female adolescents in Iran.* Iran J Reprod Med Vol. 11. No. 2. pp: 101-110, February 2013.

Ross, S., Baird, A. S., and Porter, C. C., 2014. *Teenage Pregnancy; Strategies for Prevention*. In Journal of pediatric and adolescent Gynecology. Volume 24, Issue 9, September 2014, Pages 266–273. In http://www.sciencedirect.com/science/article

Rubin, D., Green, C. and Mukuria, A., 2009. *Addressing Early Marriage in Uganda*. Task Order 1. Washington, DC: Futures Group, Health Policy Initiative.

Sekiwunga, R., and Whyte S. R., 2009. Poor Parenting: Teenager's Views on Adolescent Pregnancies in Eastern Uganda. *African Journal of ReproductiveHealth.*13 (4): 113–127.

Silcock, P., and Brundert, M., 2001.*The Management Consequences of Different Models of Teaching and Learning*. London: Paul Chapman.

Stanger-Hall KF, Hall DW, 2011. *Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S*. PLoS ONE 6(10): e24658. doi:10.1371/journal.pone.0024658.

Straight Talk Foundation, 2009. Assessment of the Straight Talk Foundation (STF) Peer Education Approach to Sex Education in Arua and Bugiri Districts in Uganda.

Tomasello, M. 2014. *A Natural History of Human Thinking*. Cambridge, MA: Harvard University Press

Uganda Bureau of Statistics, 2013. *The State of Uganda Population Report 2013*. Kampala: UBOS.

Uganda Bureau of Statistics, 2011. *Uganda Demographic and Health Survey*.Kampala: UBOS

United Nations 2010. *Report of the United Nations Special Rapporteur on the right to education*. Sixty-fifth session item 69 (b) of the provisional agenda, Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms. Presented to United Nations General Assembly, 2010.

UNAIDS, and World Health Organisation, 2008.World Wide HIV & AIDS Statistics Summary. www.unaids.org.

United Nations Joint Programme on HIV and AIDS, 1997. *Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: a Review Update*. UNAIDS Best Practice Collection. Geneva, UNAIDS.

United Nations Educational Scientific and Cultural Organization, 2014. *Comprehensive sexuality education: the challenges and opportunities of Scaling-up*. UNESCO, 7, Place de Fontenoy 75352 Paris 07 SP, France

United Nations Educational Scientific and Cultural Organization, 2012. *Comprehensive Sexuality Education: The Challenges and Opportunities of Scaling up*. Pages; 8, 11, 12, 13. UNECO, 7, Place de Fontenoy 75352 Paris 07 SP, France

United Nations Educational Scientific and Cultural Organization, and United Nations Population Fund, 2012. *Sexuality Education: A Ten-Country Review of School Curriculum in East and Southern Africa.* UNESCO 7, Place de Fontenoy 75352 Paris 07 SP, France and UNFPA, 605 Third Avenue New York, New York 10158 U.S.A pages 90-106

United Nations Educational Scientific and Cultural Organization, 2011. *School- Based Sexuality Education Programmes: A cost and Cost Effectiveness Analysis in Six Countries.* UNECO, 7, Place de Fontenoy 75352 Paris 07 SP, France

United Nations Educational Scientific and Cultural Organization, 2010. *Levers of Success: Case Studies of National Sexuality Education Programmes*. UNESCO 7, Place de Fontenoy 75352 Paris 07 SP, France

United Nations Educational Scientific and Cultural Organization, 2009. *International Guidelines on Sexuality Education*: An evidence informed approach to effective sex, relationships and HIV/STI education. 7, Place de Fontenoy 75352 Paris 07 SP, France. In http/www.unesco.org/new/en/hiv-and-aids/.../sexuality-education/. Accessed on 8 November 2014 at 13:14

United Nations Population Fund (UNFPA), 2015. *The Evaluation of Comprehensive Sexuality Education Programmes: A Focus on the Gender and Empowerment Outcomes*. United Nations Population Fund 605 Third Avenue New York, NY 10158 USA.

United Nations Population Fund, 2010. *Comprehensive Sexuality Education: Advancing human rights, gender equality and improved sexual and reproductive health*: A report on an International Consultation to Review Current Evidence and Experience, Bogotá, Colombia,

December 2010. In http://www.unfpa.org/sites/default/files/resourcepdf/Comprehensive%20Sexuality%20Education%20Advancing%20Human%20Rights%20Gender%20Equality%20and%20Improved%20SRH-1.pdf. Accessed on 17 12 2014 at 11:16 AM.

Wallace A., 2011. *Adolescent Pregnancy and Policy Responses in Uganda*. Africa Portal November 2011. In http/www.africa portal.org Accessed on 2nd December, 2014.

Weinreich. P, 1986. *The operationalization of identity theory in racial and ethnic relations* Cambridge University Press.

World Health Organisation, 2014. *Maternal, new born, child and adolescent health*. Adolescent development. In http://www.who.int/maternal_child_adolescent/topics /adolescence /dev/ en/. Accessed on 17th December 2014 at 10:36 AM.

World Health Organisation, 2011. *Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries*. Geneva: World Health Organization.

World Health Organisation, 2009. *Practical guidance for scaling up health service innovations*. Geneva: World Health Organization.

World Health Organisation, 2005, *The Bangkok Charter for Health Promotion in a Globalized World*. 6th Global Conference on Health Promotion, Bangkok, Thailand, 11 August 2005. http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/7

World Health Organisation, 1995. *Expert Committee Recommendation on Comprehensive School Health Education and Promotion.* Geneva: World Health Organization.

World Health Organisation, 2012. *School health and youth health*. (Online) Available at: http://www.who.int/school_youth_health/en

World Health Organisation, 1986. *Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa. 1986. http://www.who.int/hpr/docs/ottawa.html

APPENDICES

APPENDIX I: QUESTIONNAIRE FOR TEACHERS

Dear Respondent

My name is Mystica Acheng Jameto, a student of Uganda Martyrs University, pursuing a Masters Degree in Public Health. I am carrying out research on Exploring School Based Sexuality Education Programmes in Bugiri District: A Case for Primary Schools. I kindly request you to provide me with information. It will be treated as confidential and used for academic purposes only.

Instructions:

1. Please do not put your name on the questionnaire since all responses are confidential.
2. Follow the instructions for each question
3. Return the questionnaire in the envelope provided.

SECTION A: BACKGROUND INFORMATION ABOUT TEACHERS *(tick the right option or fill the right answer in the spaces provided)*

Name of the school____

1. What is your gender?
   1. Male ☐ 2. Female ☐
2. How old are you?
   1. 20-25 ☐ 2. 26-30 ☐ 3. 31-35 ☐ 4. 36-40 ☐
   5. 41-45 ☐ 6. Above 45 years ☐
3. What is your highest education level attained?
   1. Certificate ☐ 2. Diploma ☐ 3. Degree ☐
   4. Other (Specify)…………………………………………..
4. How many years have you been teaching in this school?
   1. Less than a year ☐ 2. 1-2 years ☐ 3. 3-4 years ☐ 4. 5-6 years ☐
   5. Above 6 years ☐
5. Nature of employment
   1. Permanent ☐ 2. Probation ☐ 3. On contract ☐

SECTION B: NATURE OF SEXUALITY EDUCATION PROGRAM AVAILABLE TO PUPILS

1. Does your school deliver sexuality education?

1. Yes ☐
2. No ☐

If No to Qn 2 above, Why?..

....

2. What type of sex education program is currently being taught in your school?

1. Abstinence-only ☐ 2. Abstinence only until marriage ☐
3. Comprehensive sexuality education ☐
4. Other (Specify)…………………………………………

4. Does your program provide information on:

Item	To a big extent	To a small extent	Not at all
1. Human development			
2. Sexually transmitted diseases			
3. Teen pregnancy			
4. Abortion			
5. HIV and AIDS			
6. Condoms			
7. Drug abuse			
8. Sexual behaviour			
9. Contraceptives			

5. How is sexuality education taught in your school?

1. Integrated in other subjects ☐ 2. Taught during Co-curricular activities ☐
3. Other (Specify) ………………………………………….

SECTION C: FACTORS INFLUENCING THE NATURE OF SEXUALITY EDUCATION PROGRAMMES DELIVERED TO PUPILS

a) Knowledge on sexuality education

1. Do you teach sexuality education in the school?

1. Yes ☐ ⟶ Skip to Qn. 3

2. No ☐

2. If **No** to Qn. 1 above, Why?..

……………………………………………………………………………………………………

3. Are you specifically trained in sexuality education?

1. Yes ☐

2. No ☐ ⟶ Skip to Qn. 5

4. If Yes to Qn. 3 above, to which level are you trained?

1. Certificate ☐ 2. Diploma ☐ 3. Degree ☐ 4. Workshops/Seminars ☐

5. If **No** to Qn 2 above, how did you get information on sexuality education?

1. Literature (books, newspaper, pamphlets) ☐

2. Media (Radio, TV) ☐

3. Health facility ☐

6. Do you feel you have adequate knowledge to teach sexuality education?

1. Yes ☐

2. No ☐

b) Time Allocation

1. About how many lessons in a week is sexuality education allocated? ……………………

2. How long is a lesson?

1. 10-20 minutes ☐ 2. 21-30 minutes ☐ 3. 31-40 minutes ☐

4. Above 40 minutes ☐

3. Do you teach all the lessons on sexuality education as intended?

1. Yes ☐

2. No ☐

4. If No to Qn. 3 above state Why? ……………………………………………………………......

……………………………………………………………………………………………………

5. In your own opinion do you feel this time is adequate?

1. Yes ☐

2. No ☐

6. If No to Qn. 5 above explain……………………………………………………………………..

……………………………………………………………………………………………………

7. Do you teach all the topics in the syllabus?

1. Yes ☐

2. No ☐

8. Are there some topics that you feel uncomfortable when teaching?

1. Yes ☐

2. No ☐

9. If No to Qn. 5 above explain…………………………………………………………………

……………………………………………………………………………………………………

10. Now that sexuality education is not examinable do you assess if learners acquire necessary knowledge on the subject?

1. Yes ☐

2. No ☐

11. If No to Qn. 12 above explain………………………………………………………………..

……………………………………………………………………………………………………

c) Mode of teaching

1. Do you have adequate resource material in teaching sexuality education?

1. Yes ☐

2. No ☐

2. If Yes to Qn. 1 are they age-appropriate

1. Yes ☐
2. No ☐

3. What teaching approaches do you employ in teaching sexuality education?

1. Role-play ☐ 2. Discussion ☐ 3. Enquiry method ☐

4. Lecture method ☐ 5. Other (Specify) …………………………………………

4. How often do your test learners on the subject?

1. Always ☐ 2. Sometimes ☐

5. Is there anything that you feel the Ministry of Education needs to do to enhance learning of sexuality education?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

…………………………………………………………………………………………………

d) Cultural Factors

1. What is the attitude of parents towards teaching sexuality education to their children?

1. Positive ☐
2. Negative ☐

2. If Yes to Qn. 1 above what reasons did the parents put forward………………………………..

…………………………………………………………………………………………………

3. How confident/comfortable are you when teaching the subject to students of opposite sex?

1. Uncomfortable ☐ 2. Comfortable ☐ 3. Fairly comfortable ☐

4. Can you please explain in detail?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

5. What do you think can be done to enable you teach sexuality education better?

…………………………………………………………………………………………………

…………………………………………………………………………………………………

6. Do you encounter some problems in teaching sexuality education?

1. Yes ☐
2. No ☐

7. If **Yes** to Qn. 7 above, state them

……………………………………………………………………………………………………
……………………………………………………………………………………………………

SECTION C: USEFULNESS OF THE EXISTING SEXUALITY EDUCATION PROGRAMMES

1. How would you rate teaching of sexuality education in this school?

 1. Poor ☐ 2. Fair ☐ 3. Good ☐

2. The existing sexuality education program has created sexual awareness among the pupils?

 1. To a big extent ☐ 2. To a small extent ☐ 3. Not at all ☐

3. The existing sexuality education program has offered guidance pupils about sexuality in your school?

 1. To a big extent ☐ 2. To a small extent ☐ 3. Not at all ☐

4. Does your program have provisions for parents and their children to work together toward a better understanding of sexual attitudes and responsibilities?

 1. Yes ☐

 2. No ☐

5. Are you aware of any pupils from your school who have had a pregnancy in the past five years?

 1. Yes ☐

 2. No ☐

6. Has the pregnancy rate among school pupils increased or decreased in the past five years in your school?

 1. Increased ☐ 2. Decreased ☐ 3. Remained the same ☐

 4. Don't know ☐

7. In your opinion, is teaching of sexuality education effective in your school?

 1. Yes ☐

 2. No ☐

8. Generally, what is your opinion on sexuality education in primary school?

……………………………………………………………………………………………………

Thank you very much

APPENDIX II: FOCUS GROUP DISCUSSION FOR PUPILS

1. What do understand about sexuality education?
2. Is sexuality education taught in your school?
3. What type of sex education program is currently being taught in your school?
4. Which topics do you learn in sexuality education lesson?
5. Do you think that sexuality education gives you information that prepares you when you decide to have sex?
6. What do you understand about adolescent pregnancy?
7. Do you share sexuality education messages that you learn in school with your peers? Probe (What kind of messages? How the messages help you?)
8. What does your parent do to support you in learning of sexuality education?
9. How do you feel about topics on preventive measures topics of sexuality education such as condom use and abstinence?
10. In the school we learn many subjects. How do you rate sexuality education as a subject? Probe (Is it boring? Is it useful to you?)

Thank you very much

APPENDIX III: INTERVIEW SCHEDULE FOR KEY INFORMANTS

1. Have you heard of sexuality education in schools?

    1. Yes ☐
    2. No ☐

2. What do you know about the subject? …………………………………………………………

………………………………………………………………………………………………………

3. Is the District taking any active role in supporting of sexuality education in schools?

    1. Yes ☐
    2. No ☐

4. If yes which role is it taking? ....

……………………………………………………………………………………………………..

5. How would you rate the role the District is taking in support of sexuality education?

    1. Low ☐ 2. Average ☐ 3. High ☐

6. In your opinion is there anything you feel the Ministry of Education needs to do to support the education sector on sexuality education?

    1. Yes ☐
    2. No ☐

7. If yes what? ……………………………………………………………………………….......
………………………………………………………………………………………………………

Thank you very much