UNIVERSITY OF NAIROBI
DEPARTMENT OF SOCIOLOGY

AN ASSESSMENT OF THE INFLUENCE OF LIFE SKILLS EDUCATION ON
REPRODUCTIVE HEALTH BEHAVIOUR OF ADOLESCENT GIRLS’ IN PUBLIC
SCHOOLS IN KIBERA, NAIROBI.

BY
GLADYS K. ANYA
C50/8383/2001

A RESEARCH PAPER SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE AWARD OF THE MASTER OF ARTS DEGREE IN
SOCIOLOGY. (RURAL SOCIOLOGY & COMMUNITY DEVELOPMENT)

SEPTEMBER, 2013
DECLARATION

I declare that this project paper is my original work and has not been submitted for a degree to any other university.

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Gladys K. Anya Date

This project paper has been submitted for examination with my approval as the University Supervisor:

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Prof. Charles Nzioka Date
DEDICATION

This project paper is dedicated to my late sister, Zipporah Nyakerario, whose love, care and concern for us, her younger siblings left a mark in our lives.

To my dear husband Joshua Anya, for the confidence and encouragement throughout the research process.
ACKNOWLEDGEMENTS

I am forever grateful to the Almighty God for the opportunity to conduct and complete this task in sound health.

I am highly indebted to my supervisor, Prof. Charles Nzioka. It is through the probing, encouragement and guidance that I was able to make each step. Prof. Nzioka took time to understand my work, provide guidance and clarify gray areas. I was indeed honoured to have him as my supervisor and teacher.

Special gratitude to Board of Postgraduate Studies – University of Nairobi, for extending my enrolment period at the University, hence the completion of this research project.

To the respondents, teachers, experts in the field of Life Skills Education in Nairobi. Thank you for opening your offices and classes to me and for creating time to engage me through this project.

Finally to my dear family, husband Joshua and our children, Selma, Edmund and Sandra. Special thanks for your patience, love and support through this process.

May almighty God bless you.
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ARH&amp;D</td>
<td>Adolescent Reproductive Health &amp; Development</td>
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<td>APHRC</td>
<td>African Population and Health Research Centre</td>
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<td>DVD</td>
<td>Digital Versatile Video</td>
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<td>HBM</td>
<td>Health Belief Model</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>KIE</td>
<td>Kenya Institute of Education</td>
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<td>LSE</td>
<td>Life Skills Education</td>
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<td>PBT</td>
<td>Problem Behaviour Theory</td>
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<td>SLT</td>
<td>Social Learning Theory</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TOT</td>
<td>Trainer of Trainees</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>UNICEF</td>
<td>United Nations Children's Education Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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ABSTRACT

Adolescence is a very fundamental stage in life where emotional, physical and biological transformation takes place in preparation for future development of a girl. Throughout this period many young girls struggle to cope with the changes in their day to day life. This changes call for physical, emotional & social skills in order to deal with challenges that the changes bring along.

One key development during adolescent years is the development of the reproductive system. This study focused on the reproductive health behaviour & knowledge of adolescence and how Life Skills Education has supported the school going girl in Kibera to manage and handle the changes of this stage in day to day life and especially in regards to reproductive health. It is evident that when reproductive health of an adolescent is not well managed, the future could present multiple challenges that could hinder the realization of the potential of the individual girl.

This study aimed at assessing the exposure of the girls to LSE and the benefits that LSE can realize. It also looked at the challenges that are faced during the learning process. While appreciating the many other aspect of the adolescent age that hinder the young people's potential, reproductive health behaviour remains a key concern hence this study.

Today adolescents face challenges that prior generations did not face for multiple reasons. In an effort to prepare this age group to cope and deal with the challenges of adolescence, the Ministry of Education in conjunction with the Kenya Institute of Education introduced Life Skills Education as part of the school curriculum to train school going adolescents on handling relevant core areas of this stage. The main goal of the Life Skills approach is to enhance young people's ability to take responsibility for making choices, resisting negative pressure, meet the demands of everyday life and avoiding risky behaviour.

A randomly selected sample of adolescent girls attending public school in Kibera between the age of 15-19 years was targeted making 10% of the school going girls in the study area. Key findings noted the need for more emphasis on dealing with peer pressure, problem solving and stress management, these being difficult areas for this age group. It also found that self awareness and basic knowledge of adolescence was well understood and interpreted.

Key recommendation included development of age friendly content and strategy of implementation. In conclusion LSE remains extremely relevant to this age-group.
CHAPTER ONE: INTRODUCTION

1.1 Background

The term "Adolescence" is used to describe the period between 10 and 19 years of age and is understood in different ways in different cultural contexts. Almost universally, it is seen as a time of transition between childhood and adulthood. It is further viewed as a period of physical and psychological changes associated with puberty, and of preparation for the roles, privileges and responsibilities of adulthood (Williams, Holmbeck et al. 2002).

Adolescence is one of the most complex transitions in one's life time. The adolescence period is characterized by rapid changes and may be divided into three main stages generally: Early adolescence (10-13 years) which is characterised by a surge of growth, and the beginnings of sexual maturation. At this stage, young people also start to think abstractly. In mid-adolescence (14-15 years), the main physical changes are completed, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group, although families usually remain important. Thinking becomes more reflective. In later adolescence (16-19 years), the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions. These changes take place at a different rate for each individual and can be a period of anxiety as well as pride.

The experiences encountered during the adolescence period have significant implications and consequences for later life. As they develop, adolescents adopt new roles of social responsibility; acquire skills and access opportunities necessary for functioning in adult life. Nevertheless, during these formative years, adolescents are subjected to many influences dominating their internal and external environment. These include: parents, teachers, peer groups, health care providers, and media, religious and cultural norms in the community. Knowledge of the significant rapid physical, mental and social changes occurring during this critical stage of life helps adolescents to absorb and adapt to these changes and enables them to avoid becoming victims of serious and often detrimental consequences. It is acknowledged that the events of this crucial formative phase can shape an individual's entire lifespan (Williams, Holmbeck et al. 2002).
Many adolescents managed to negotiate their way through this critical transition. With caring families, good schools, health care, and supportive community institutions, they have grown up healthy and vigorous, reasonably well educated, committed to families and friends, and prepared for the workplace and the responsibilities of citizenship. For many others, however, the obstacles in their path have impaired their physical and emotional health, eroded their motivation and ability to succeed in school and the workplace, and damaged their human relationships.

Work undertaken to understand the context of young people’s lives and to identify the factors that affect their reproductive health found several levels of barriers. At the individual level there is incomplete knowledge; social norms; confusion resulting from mixed messages; lack of skills and ability to communicate with partner, parents, peers, and others; physical and psychological inaccessibility of services. At the family and community level barriers include social norms that disapprove of young people’s sexuality, and the tendency to withhold information for the fear that the information will encourage young people to “experiment.” Finally at health system level there is the attitude of health staff; lack of confidentiality; a shortage of trained staff and policies on sexual matter (Francisco 2002).

Even though these barriers affect all adolescents, adolescents who live in conditions characterised by poverty, gender inequality and social marginalisation are more disadvantaged. Sexual and reproductive ill-health including HIV and AIDS thrive in conditions of poverty, powerlessness, marginalisation, and social instability (Rae 2001). These conditions may affect the reproductive health of adolescents by limiting their access to information about their reproductive health; exacerbating unsafe sexual practices, unwanted pregnancies and unsafe abortions; and increasing their exposure to sexually transmitted infections (STIs), including HIV/AIDS.

A study comparing the impact of socioeconomic deprivation on risky sexual outcomes in rural and urban Kenya concluded that, although poverty is significantly associated with the examined sexual outcomes in all settings, the urban poor are significantly more likely than their rural counterparts to have an early sexual debut and a greater incidence of multiple sexual partnerships (Nii-Amoo Dodoo 2007).
Another study done in slums in Nairobi concluded that adolescent boys and girls in the slums experience far worse reproductive health outcomes than their colleagues elsewhere in Kenya. They initiate sexual and reproductive activities much earlier in conditions of poor access to family planning and health services as a result of social, geographic isolation, low income, and illegal residence and are hence at increased risks of unwanted pregnancies, unsafe abortion and sexually transmitted infections, including HIV (APHRC 2002).

The studies related the early sexual activities to the insecure environments these adolescents grow up in or move into, their lack of education; domestic violence and child abuse and often the need to earn money through commercial or transactional sex (APHRC 2002; Nii-Amoo Dodoo 2007).

Even though reproductive health problems affect both boys and girls, research has shown that girls are usually more affected than boys. About 75% of all young people living with HIV in sub-Saharan Africa are female. Prevalence is higher in adolescent girls than in adolescent boys in all countries, with the ratio of girls to boys living with HIV ranging from 20 to 10 in South Africa, to 45 to 10 in Kenya and Mali (Bearinger, Sieving et al. 2007).

Sexual maturity brings with it noticeable changes in a girl’s appearance, which in turn affects the way a girl regards herself and the way she is treated by her family and the wider world. For girls, sexual maturity takes place closer to twelve and for boys closer to fourteen. For many adolescent girls adolescence is one extended crisis and the situations they face are either life-changing or life-threatening, or both. Girls are subjected exclusively, or in much greater measure than boys, to irrevocable losses to their well-being and bodily integrity, such as forced sex, domestic violence, child marriage, pregnancy, infection, including HIV, and the loss of parts of their bodies (Bruce 2006). Violence is frequently directed towards girls, who lack the social and economic status to resist or avoid it such as those living in slum areas. In poor urban enclaves in sub-Saharan Africa about two-thirds of the girls will report their first sexual experience as forced or “tricked” (Bruce 2006).
Some of these other reasons include early marriage, sexual maturity (whereupon girls and/or their parents believe they no longer need to attend school because they are of marriageable age), pregnancy, low self-confidence (in that girls are unable to resist sexual pressures), and sexual harassment by male teachers and boys. Girls may also drop out of school because they feel uncomfortable if they are in their teenage years while in primary school. Girls are often older than their male counterparts, because girls usually start school at a later age and may repeat grades due to the difficult curriculum or having to perform household chores in lieu of schoolwork. In addition, parents and sometimes teachers place a low value on girls’ education, which contributes to their increased drop rate. Girls who cannot overcome these barriers are often denied the chance to enjoy healthy and productive adult lives (Mensch and Lloyd 1998; Thomas 2002).

By their very nature, informal settlements are replete with poor environmental factors that predispose their inhabitants including adolescent girls to poor health outcomes. These settlements are usually illegal or quasi-legal and built in marginal areas in contravention of current planning and building regulations. They do not receive the usual services such as supply of potable water, waste-water drainage, refuse collection and sewerage services from the urban governments. Yet in many developing countries a large proportion of the population migrating to the urban centres continues to settle in these areas (Rae 2001; APHRC 2002; Amuyunzu-Nyamongo and Taffa 2004).

Many people consider girls’ education to be one of the best investments in international development. An association exists between improvements in national development indicators and an increase in the number of girls receiving formal schooling, independent of improvements in academic quality. Women who complete their education are more likely to lead productive lives, support their families, take good care of their children, and practice healthy behaviours than women with little or no education (Thomas 2002).
An emerging body of evidence has confirmed that school enrolment is an important determinant of girls’ health and well-being. Globally, enrolled girls are less likely to have had sex, and if they are sexually active, they are more likely to use contraception than non-students of the same age (Bruce 2006). In Kenya, initial enrolment rates are roughly equal, but as girls enter their adolescent years, they drop out at faster rates than boys. Poverty is a primary reason girls (as well as boys) drop out of school. However, girls also drop out for other reasons directly or indirectly related to reproductive behaviours (Mensch and Lloyd 1998; Thomas 2002).

Life skills programmes aim to influence health and social behaviour and includes five key psycho-social aspects namely: self-awareness (self-esteem) and empathy; private communication and interpersonal relationships; decision making and problem solving; creative thinking and critical thinking; and coping with emotions and stress (UNICEF 2003). Life skills objectives is to foster positive behaviours across this range of psycho-social skills, and to change unacceptable behaviours learned early, which may translate into inappropriate and risky behaviour at a later stage of life. Life skills programmes is one way to offer the information and skills that adolescent girls need to deal with issues such as abstinence, sexual abuse, preventing pregnancy and STIs. (Gachuhi 1999; Magnani, MacIntyre et al. 2005; Bearinger, Sieving et al. 2007)

Sex education programmes grounded in evidence-based approaches are a cornerstone in reducing adolescent sexual risk behaviours and promoting sexual health. In addition to providing accurate information about consequences of STIs and early pregnancy, such programmes build life skills for interpersonal communication and decision making. Such skills are best learned through experiential activities which are learner centred and designed to help young people gain information, examine attitudes and practice skills (Gachuhi 1999; Magnani, MacIntyre et al. 2005; Bearinger, Sieving et al. 2007).
1.2 Problem Statement:

In recent years, adolescent sexuality and reproductive health have become a source of increasing social concern because of the exposure to the possible negative impacts of early sexuality, which may affect other aspects of adolescent development. Many adolescents are already sexually active with research showing that in many countries, 30% or more of adolescents experience intercourse before the age of 15 (Bearinger, Sieving et al. 2007; Castagnaro 2007). A survey in Kenya with over 8000 girls and boys aged 11-16 found 53% to be sexually active, the median age of first intercourse being 12 years old (Maticka-Tyndale 2005).

The social concern of the deteriorating level of reproductive health risks in society today, ripples across all corners of our country. It is now more common than before to read narrations of 11, 12 or 14 year old girls not to mention the statistics of the older adolescents, giving birth at very tender ages. This age-group is not ready to assume such responsibility both mentally, socially or economically. While the deteriorating social fabric continues, it affects numerous segments of the society hence the definite need to understand how best this threat can be managed.

An assessment done in Kibera by one NGO identified some of the reproductive health-related causes of primary school dropout among girls to include: forced/early marriages, pregnancy/early maturity/love affairs, lack of guidance/counselling/role models, traditional beliefs (i.e., female circumcision) and sanitary needs (Thomas 2002)

Early sex is associated with health problems including: Sexually Transmitted Infections (STIs) like HIV and AIDS; early and unwanted/unplanned pregnancy, unsafe abortion, sexual coercion or violence and infertility (Romero and Ray 2007). These outcomes are devastating for the adolescents, their families and community in general and put the health and prosperity of society at risk.
In an attempt to prevent HIV infection among this vulnerable population and save the next generation, Ministries of Education including that of Kenya have introduced HIV prevention into formal curricula in the form of life skills training/education (USAID 2002). The ministry of education was well-positioned to play a role in HIV/AIDS prevention and other age related challenges, because the schools they manage help shape social norms, values, and behaviour among a large proportion of young people. This is especially so at the early primary level. WHO defines life skills as the abilities for adoptive and positive behaviour that enable individuals to deal effectively with the demand and challenges of everyday life (WHO 2003). The ability to make decisions, solve problems, capacity to think creatively, and critically, ability to communicate effectively, establish and maintain interpersonal relations, knowledge of self, capacity to feel empathy, handle emotions and manage tension and stress. UNICEF on the other hand defines life skills as a behaviour change or behaviour development approach designed to address a balance of three areas: knowledge, attitude and skills (UNICEF 2003). UNICEF further adds that life skills should not only address knowledge and attitude change but make important behaviour change (UNICEF 2003).

A review of the effect of 83 evaluated sex education programmes, including 18 in developing countries showed substantial evidence that curriculum-based programmes can have positive effects on risky sexual behaviours in young people (Bearinger, Sieving et al. 2007).

Life skills education is one way of helping children, youth and their teachers to respond to situations requiring decisions which may affect their lives. Therefore life skills education programmes promote positive health choices, taking informed decisions, practising healthy behaviours and recognizing and avoiding risky situations and behaviour (Bearinger, Sieving et al. 2007).

The study therefore examined the extent in which adolescent girls in Kibera slums were influenced/impacted by life skills learned in schools in making reproductive health decisions. The study was guided by the following research questions.
1.3 Research Questions

1. To what extend have Adolescent girls in Kibera been exposed to and understood life skills imparted on them through life skills education?

2. To what extend have Adolescent girls in Kibera benefitted from the life skills imparted on them?

3. What challenges do the multiple sources of information present to LSE learning amongst the adolescent girls?

1.4 Objectives of the Study

The general objective of this study was to assess the influence of life skills education on reproductive health behaviour of adolescents girls in Kibera. The following were the specific objectives:

1. To assess the confidence level of life skills education knowledge among adolescents girls in Kibera

2. To determine actions taken by adolescent girls in Kibera to avoid and address reproductive health risks.

3. To determine what sources of information are available to the adolescent girls in Kibera.
1.5 Significance of the Study

Adolescents today face challenges that prior generations did not face in similar scale due to issues such as globalization and media influence. It is the obligation of schools, communities, parents and government leaders to prepare adolescents for a rapidly changing, and often confusing, world. Adolescents need guidance to pass safely into adulthood, and it is our moral obligation to ensure that adolescents in every community and nation have the opportunity to build better and healthier lives for themselves and their families. However, the situation on the ground should be understood first before any strategies to protect adolescents are developed.

The health and, even more importantly, the knowledge, attitudes and practices of adolescents are regarded as essential factors when predicting the process of epidemiological transition of a population. The current lifestyles of adolescents, such as eating habits and reproductive behaviour, are crucial for the health and disease patterns that will be observed in the future. Knowledge of the significant rapid physical, mental and social changes occurring during this critical stage of life helps adolescents to absorb and adapt to these changes and enables them to avoid becoming victims of many serious illnesses. Studies in this area such as this one will help in the prevention and understanding of diseases in the future.

Education systems must also respond to the challenges of the negative impacts of random sexual behaviour. But, more than this, education systems have an essential role to play in reversing the very pandemic that threatens it. Young people, especially those between 5 and 14 years, both in and out of school youth, offer a window of hope in stopping the spread of reproductive health related diseases and risks, if they have been reached by Life Skills Education. In the absence of a cure, the best way to deal with e.g. HIV/AIDS is through prevention by developing and/or changing behaviour and values (Gachuhi 1999). The few countries that have successfully decreased national HIV prevalence have achieved these gains mostly by encouraging safer sexual behaviours in adolescents (Bearinger, Sieving et al. 2007).
Early adolescence marks a critical time of physical, developmental, and social changes. Interventions during early adolescence may be more effective in shaping healthy attitudes and behaviours than in late adolescence, when attitudes and behaviours are more established. Young adolescents are also more likely to still be in school and less likely to have begun sexual activity (USAID 2008). This study therefore aims at understanding the role of LSE in laying a foundation for adolescents' health. LSE has been introduced in Kenya's school curriculum to address the problems that the adolescents encounter by the Ministry of Education and Kenya Institute of Education. It is however not an examinable component of the curriculum and therefore not much emphasis has been given to Life Skills education as a whole. The Kenya Institute of Education (KIE) developed Life Skills Education curriculum with the objective of developing youth who can deal with the challenges of everyday life and adolescence plays a very important role in setting this stage. The KIE targets both primary and secondary pupils in its Life Skill Programmes

1.6 Scope and Limitations

The study mainly focused on adolescent girls living in Kibera. Other studies cited above indicated that girls and especially those living in slums were vulnerable to adverse reproductive health problems. This study specifically targeted those girls who have been exposed to life skills education through the school education system in order to determine the extent to which they have been influenced by the knowledge received in facing day to day challenges. The selection of the sample was done with the assistance of schools which confirmed life skills education as a taught subject in accordance with the school curriculum. Noting that the target age group was between 15 – 19 years, the study concentrated on secondary school adolescent girls.

Limitations of this study are that the study only focused on a locality that is mainly urban in characteristics, leaving out the rural adolescent, secondly, the focus on girls attending public schools only left a section of the population that attends non-formal schools.

Whereas the general Life Skills scope of study is wide, this research aimed at identifying with specific components of LSE that have a great impact on one's social, economic and spiritual wellbeing. These include emotional skills, social skills and thinking skills.
1.7 Operational Definition of Key Terms

a) **Adolescence** is defined by the World Health Organization as the period of life between 10 to 19 years of age.

b) **Life Skills Education** is defined by the Kenya Institute of Education as abilities to enable an individual develop adaptive and positive behaviour so as to effectively deal with challenges and demands of everyday life. In context of this study, Life Skills Education shall focus on the psychosocial balance of Reproductive Health of the population under study.

c) **Reproductive Health** as defined by the World Health Organization in the health framework as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. In context of this study Reproductive Health shall focus more on mental and social wellness.

d) **Sexuality** “is a fundamental part of being human. It relates directly to sexual behaviour as well as sexual and reproductive health and well-being. It is an important and pleasurable element in many intimate relationships. While it is typically associated with sex and other biological aspects such as reproduction, sexuality is profoundly influenced by social and cultural factors. Gender and sexual norms, power relations, hormones, and individual experiences all influence a person’s experience of sexuality.”

e) **Social.** In context of this study, social health refers to the health of a person in reference to his or her ability to interact with others and thrive in social settings.

f) **Emotional** according to WHO is the wellbeing in which the individual realizes his/her own abilities, can cope with the normal stresses of life, and work productively and fruitfully, and is able to make a contribution to his or her community. In context of this study emotional health shall means the same.

---

2 Population Council
CHAPTER TWO: LITERATURE REVIEW

2. Introduction

This chapter focuses on literature review based on the objectives of the study. It begins by giving a brief background on adolescents, and the reproductive health issues they face including their awareness of these issues. It then explores approaches to addressing reproductive health problems adolescents face and some of the challenges faced especially with exposure to life skills as a tool to managing behaviour change. It finally gives the theoretical/conceptual framework to the study.

2.1. Adolescents and Reproductive Health Issues

Adolescence is a transitional developmental phase from the world of the child to the world of the adult and is characterized by more biological, psychological, and social role changes than any other stage of life except infancy. Moreover, there are two transition points during this single developmental period; the transition to early adolescence from childhood and the transition to adulthood from late adolescence (Steinberg, 1996 cited in Williams, et. al). During this stage the body matures and the mind becomes more questioning and independent (Williams, Holmbeck et al. 2002).

The adolescent stage has often been described as a contradiction or paradox since adolescents are no longer children, and again not yet adults. Biologically, they can become mothers and fathers, but, without being ready for the responsibility. They feel a growing sense of independence, but depend on adults for their material needs. There are differences in the pace and quality of development among adolescents of the same age and sex, between the sexes, and among adolescents from different cultural, social and economic backgrounds (Williams, Holmbeck et al. 2002). Developments occurring during early adolescence may be marked by anxiety as the adolescents wonder what is happening to their bodies. Girls may be embarrassed about growing breasts, or embarrassed if they are late developers. Boys too become very anxious about the changes to their bodies. Even though such concerns are generally transitory, some young people develop low self-esteem and depression (WHO 2002).
Social changes also affect adolescents in different ways. On the one hand, boys usually take on a masculine identity which emphasizes risk taking, aggressive and dominating behaviours hazardous to themselves and to girls and women. For those boys, in the lower income classes, there is also the possibility of being withdrawn from school under pressure to provide income for their families, as well as the risk of joining criminal gangs and in some settings being drawn into armed conflicts as soldiers (WHO 2002).

On the other hand, girls’ self esteem and sense of worth may be increasingly centred on their marriage ability, sexuality, and fertility. A girl’s body and its ability to reproduce, give pleasure, and to undertake domestic work, may be seen by others and girls themselves as their sole social and economic asset. This stage also brings the possibility of forced departure from school, economic and sexual exploitation, forced marriage, early childbearing, genital cut, migration for work, and increasing limitations placed on their participation in public and civic life (Bruce 2006; Parker and Finger 2008).

Adolescents are increasingly exposed to risks and pressures on a scale that previous generations did not face. Globalisation and modernity have accelerated change while at the same time, the structures that protected previous generations of young people are being eroded. In pre-modern society, training and preparation for adulthood was exclusively a family and community affair. The onset of puberty was often the occasion for sexually segregated rituals like initiation to signal the beginning of adulthood, at which time information about sexuality, reproduction, and adult roles was shared between men and boys and between women and girls. Today, children are likely to be in school at the time of physical maturation and, therefore, exposed to non-familial attitudes, information, and ideas emanating from teachers, peers, media and a centrally designed curriculum (Mensch and Lloyd 1998).

Adolescents today therefore face, and are expected to process, conflicting messages on how to address the daily choices which have lifelong consequences to their development including sexuality and sex in an increasingly technological and information-oriented society. They get information from a wide variety of sources including their peers, parents, popular media and websites. Some of this information
is accurate, while some is not. Therefore misconceptions about sex can and do spread (Castagnaro 2007). Millions were denied the essential support they need to become knowledgeable, confident and skilled adults.

Adolescence is also the time when many people start to engage in sexual activity. While age at marriage is rising in virtually every country, age at first intercourse is falling. A large proportion of adolescents are engaging in premarital sexual activity (WHO 2003; Bearinger, Sieving et al. 2007). This activity is often not planned, and many young people may be unlikely to use any kind of protection thereby exposing themselves to reproductive health risks including getting infected with STIs and/or HIV, unwanted/unplanned pregnancy, unsafe abortion, sexual coercion or violence and infertility (WHO 2002; WHO 2003).

Adolescent pregnancies and births especially before age 15 carry higher risks for both the mother and the newborn. At age 15, a girl’s pelvic bones, birth canal, and muscular growth are not fully developed. Pregnancy before full development exposes girls to greater risks of miscarriage, obstetric complications (hypertension, obstructed and prolonged labour, vaginal tearing, fistula, and haemorrhage), and death. Pregnant girls under age 15 are twice as likely to experience premature labour and four times more likely to die from pregnancy related causes than women over age 20. Early childbirth is also a cause of premature delivery, low birth-weight, stillbirth, and the death of the newborn (WHO 2003; Parker and Finger 2008). Additionally adolescents who experience an unplanned pregnancy may resort to abortion, often under unsafe conditions.

Other important consequences of unprotected intercourse include sexually transmitted infections (STIs). Of an estimated 340 million cases of curable STIs occurring annually in the world, at least one-third are in people under age 25. In addition, half of all new human immunodeficiency virus (HIV) infections occur among 15-24-year-olds. Almost two-thirds of all youth living with HIV worldwide are found in Sub-Saharan Africa. Adolescent girls are more vulnerable than either boys or adults to STIs mainly due to some biological reasons. Girls have a large mucosal surface area exposed to infection and have not yet developed mature mucosal defence systems, the cells that line the opening of the cervix are particularly susceptible to chlamydia, gonorrhoea and HIV (WHO 2003; Bearinger, Sieving et al. 2007).
Many STIs can be cured. However, shame and fear of reprisals may prevent young people from seeking timely treatment for an STI. The consequences of untreated or incurable STIs include infertility, illness and even death, for both the young people infected and for their children. The social and emotional costs of infertility can be especially high for women in contexts where parenthood is highly valued. Failure to have children can result in emotional trauma, family neglect, abuse or abandonment (WHO 2003).

Moreover, in much of the developing world, some young people experience pressure to become sex workers as the only available option for contributing to the food and shelter needs of their family. Those who become sex workers are at heightened risk of STIs, pregnancy, and violence, but may avoid health care for fear of being judged or stigmatised. In many societies, sex is not openly discussed (WHO 2003; Bearinger, Sieving et al. 2007; Parker and Finger 2008).

Most young people at risk for HIV infection or already living with HIV/AIDS reside in the world’s poorest regions; their vulnerability to HIV operating within a broader context of poverty, which may include lack of access to education, economic opportunities, and health-related services. A study comparing reproductive health issues between rural and urban areas revealed that sexual activity begins earlier in the slums than in Kenya as a whole, especially among female adolescents. The majority of adolescents were sexually experienced but contraceptive use, including condom use, was generally low which could lead to early childbearing and the incidence of unplanned pregnancies (APHRC 2002).

Vulnerability to poor reproductive health outcomes among adolescents in the slums is further aggravated by widespread misconceptions of how HIV/AIDS and other STIs are transmitted. About 90% of adolescents believed that a woman who is HIV+ will always give birth to a HIV+ child, while about 40 percent believed that AIDS can be transmitted through mosquito, flea or bedbug bites. Furthermore, a significant proportion of the adolescents (at least 20 percent) did not know that using condoms can prevent the transmission of AIDS, or believed that they could always tell if a person is HIV positive or has STIs. These misconceptions can deter effective
behaviour change that might, if successful, curb the spread of HIV/AIDS and other STIs (APHRC 2002).

The most basic needs of adolescents, regardless of culture, age, and marital status, are for accurate and complete information about their body functions, sex, safer sex, reproduction, and sexual negotiation and refusal skills. Without information, adolescents are forced to make poorly informed decisions that may have profound negative effects on their lives (Bearinger, Sieving et al. 2007; Parker and Finger 2008).

Such programmes are currently being implemented in schools, which reach large numbers of teenagers in areas where school enrolment rates are high. Interventions during early adolescence are known to be more effective in shaping healthy attitudes and behaviours than in late adolescence, when attitudes and behaviours are more established (Joyce, Askew et al. 2008; Parker and Finger 2008). In addition to providing accurate information about consequences of Reproductive health risks, STIs and early pregnancy, such programmes build life skills for interpersonal communication and decision making.

2.2. Policy on Reproductive Health and Life Skills

In 1994, the International Conference on Population urged governments to make reproductive health services accessible, acceptable and affordable to young people. Accordingly, the Kenyan government developed the Adolescent Reproductive Health and Development Policy (ARH&D) in 2003. The policy emphasized on the importance of investing in the health of the youth and the contribution it make to the overall development of the country. This policy also looked at the interlinkages between different sectors and actors for integrated quality reproductive health outcomes.

Key Adolescent health issues were addressed namely teenage pregnancy, unsafe abortion, school dropout, sexually transmitted diseases/infections including HIV and risky reproductive health behaviour.

A plan of action was developed to provide direction in the implementation of the ARHD policy. Through the plan of action, the government aimed at scaling up the
Adolescent reproductive health activities countrywide through partnerships, collaboration, networking and resource mobilization.

The Plan of Action was geared towards contributing to the achievement of the Millennium Development Goals (MDGs) particularly in promoting gender equality and empowerment of women – MDG 3, reducing child mortality – MDG 4, improving maternal health – MDG 5 and combating HIV/AIDS, malaria and other diseases.

In Kenya, it is recognized that the changing economic, social and health climate make, Adolescence and especially challenging times for young people in general and for young women in particular (Khan and Leonard 2002). Yes this period provides excellent opportunity for shaping behaviour among this group of the population through programs that aim to develop a fundamental set of skills and competencies to deal with the challenges of health, development and sexuality (Evelia and Muganda 2003)

2.3. Life Skills Education

Life Skills training and education is slowly drawing attention in addressing the challenges of day to day that adolescents face today. The main reason from assessment is the diminishing role of traditional approaches of education were older kinsmen had the responsibility of educating the youth on matters that touch on the life, behaviour, relationship, health and even spirituality. In a dynamic society, Life Skills Education adopts a comprehensive behaviour change approach that focuses on the development of the whole individual. The Life Skills approach is an interactive, educational methodology that not only focuses on transmitting knowledge but helps the youth to explore their attitudes, feelings, opinions and values thereby developing competencies to face life’s challenges effectively.
The KIE main goal of the Life Skills approach is to enhance young people’s ability to take responsibility for making choices, resisting negative pressure and avoiding risky behaviour. Through LSE learners acquire and develop skills such as critical thinking, problem solving, decision-making, interpersonal relationship stress and anxiety management, effective communication, self-esteem and assertiveness.

The need to focus on Life Skills as a critical response to the challenges facing young people today, is highlighted in a number of international recommendations, including the Convention on the Rights of the Child, the International Conference on Population and Development, and Education for All. An example of one of these highlights is the UNGASS Declaration which states that: By 2005, ensure that at least 90% and by 2010 at least 95% of young men and women have access to information, education, including peer education and youth-specific HIV Education and, services necessary to develop life skills required to reduce their vulnerability to reproductive health risks and HIV infection, in full partnership with young persons, parents, educators and health care providers. (UNGASS: 2001)

In aiming to achieve the targets set by the different declarations, the Kenya Government through the Ministry of Education and Kenya Institute of Education laid down strategies for implementation. This was with the help of UNICEF Kenya country office in 2002. Among the strategies was the development of Life Skills education material and orientation of teachers on mainstreaming Life Skills education in the curriculum. So far KIE has oriented 1120 trainers of trainers (ToTs) both teachers, education officers etc on how to mainstream Life Skills education into the regular school curriculum. Towns already trained include, Kwale, Garissa, Nairobi, Meru North, Tana River, Koibatek, Nakuru, Kajiado and Laikipia. (KIE: 2005)

2.4. Effects of Education and Life Skills on Reproductive Health

The school is increasingly becoming an important institution in the socialization and training of the next generation (Mensch and Lloyd 1998). An emerging body of evidence is confirming that school enrolment is an important determinant of girls’ health and well-being: globally, enrolled girls are less likely to have had sex, and if they are sexually active, they are more likely to use contraception than non-students of the same age (Thomas 2002; Bruce 2006; Bearinger, Sieving et al. 2007).
Attending school encourages students to become better disciplined. From prolonged experience of the almost military routines of school life, students learn to defer gratification, to apply themselves even when naturally reluctant to do so, to endure constraints and hardships in the expectation of long-term future benefits, and to take their future well-being into account in the present. They emerge from school having acquired a measure of self-confidence and a considerable sense of direction and capacity for self-control. These qualities can equip and motivate them to protect themselves against negative reproductive health outcomes including HIV infection. (Coombe and Kelly 2001)

Life skills include competencies and interpersonal skills that help people to make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize and cope with managing their lives in a healthy and productive manner. Essentially there are two kinds of skills — those related to thinking termed as “thinking skills” and skills related to dealing with others termed as “social skills”. While thinking skills relate to reflection at a personal level, social skills include interpersonal skills and do not necessarily depend on logical thinking. It is the combination of these two types of skills that are needed for achieving assertive behaviour and negotiating effectively. “Emotional” can be perceived as a skill not only in making rational decisions but also in being able to make others agree to one’s point of view. To do that, coming to terms first with oneself is important. Thus self-management is an important skills including managing/coping with feelings, emotions, stress and resisting peer and family pressure. Young people as advocates need both thinking and social skills for consensus building and advocacy on issues of concern.

The Ten core Life Skills laid down by WHO are:

- a) Self awareness
- b) Critical thinking
- c) Decision making
- d) Effective communication
- e) Coping with stress
- f) Empathy
- g) Problem Solving
- h) Interpersonal relationship
- i) Coping with emotion
Developing life skills helps adolescents translate knowledge, attitude and values into healthy behaviour such as acquiring the ability to reduce special health risks and adopt healthy behaviour that improves their lives in general (such as planning ahead, career planning, decision making and forming positive relationships). The adolescents of today grow up surrounded by mixed messages about sex, drug use, alcohol and adolescents pregnancy. On one hand, parents and teachers warn of the dangers of early and promiscuous sex, adolescent pregnancy, STDs/HIV/AIDS, drugs and alcohol and on the other hand, messages and behaviour from entertainers and peer pressure contradict those messages. Often they even promote the opposite behaviour. It is through life skills that adolescents can fight these challenges and protect themselves from teenage pregnancy, STDs, HIV/AIDS, drug violence, sexual abuse and many other health related problems.

Empirical knowledge about reproductive health issues does not automatically lead to changes in behaviour that will protect people against negative outcomes. Evidence shows that prevention information must be coupled with everyday skills to increase the likelihood that individuals will translate their knowledge into action. Life skills are social and interpersonal skills (including communication, refusal skills, assertiveness and empathy), cognitive skills (including decision-making, critical thinking and self-evaluation), and emotional coping skills (including stress management and an internal locus of control (Gachuhi 1999; Botvin and Griffin 2004).

These are abilities for adaptive and positive behaviour that enable adolescents to deal with the demands and challenges of everyday life. As earlier explained life skills can be useful in a variety of ways, such as helping students to 1) resist pressure from peers or from the media to engage in high-risk behaviours, 2) increase their self-control, 3) acquire ways to reduce stress without engaging in dangerous activity, 4) learn how to make friends and overcome isolation, and 5) learn how to avoid violence. Research shows that such skills can be effectively taught by using systematic instruction and practice through role playing.

When young people have acquired the necessary skills in a positive, safe environment, they may choose not to have sex or, for those who are sexually active, to
use condoms consistently. Life skills curricula can examine attitudes and social norms such as discrimination and peer pressure. Interactive teaching techniques allow discussion of social pressures relating to relationships and opportunities to practice negotiation, communication, and refusal skills (USAID 2002).

Life skills education provides a variety of exercises and activities in which children do something and then process the experience together, generalizing about what they learned and ideally, after much practice in the programme, attempt to apply it to future real life situations. They help children become socially and psychologically competent and to function confidently and competently with themselves, with other people and with the community.

Adolescents operate within the context of social and cultural influences. Therefore, life skills programs should give young people the skills they need to protect themselves from peer or adult coercion (Gachuhi, 1999). They should also reinforce group values against unsafe sexual behaviour, both among peers and throughout the community. One of the most important skills young people need to acquire is the ability to analyze situations, the behaviour of individuals, and the consequences of their own actions, prior to engaging in those actions. They also need to learn how to avoid certain situations. They need to understand what risky behaviour entails and how to manage or avoid risky situations (Gachuhi 1999; USAID 2002).

Life skills programmes provide an opportunity to address other social issues that young people encounter in their daily life. Sexual abuse and violence are serious problems that transcend racial, economic, social, ethnic and regional lines. Violence is frequently directed towards females and youth, who lack the social and economic status to resist or avoid it. Adolescents, children and young women and girls in particular experience increased abuse in the form of domestic violence, rape and sexual assault, sexual exploitation and/or female genital mutilation (Gachuhi 1999).
2.5. Barriers to Implementation for Life Skills & Reproductive Health Programmes

Life skills programmes, family life education, and/or reproductive health programmes for children and young people often face opposition from parents, religious and community leaders and from some youth themselves who do not understand that they are at great risk. However, a study by the Population Council in Kenya, found that a large majority of primary and secondary school teachers, as well as parents and guardians, approve of the teaching of adolescent growth and development, including topics such as STIs and AIDS, family and gender roles, reproductive physiology, puberty and menstruation (Joyce, Askew et al. 2008).

Research shows that these programmes do not lead to more frequent sex or to the earlier onset of sexual activities, as opponents fear. Nor do they lead young people to promiscuity. Recent research in Kenya suggests that family life/sex education programmes yield significant and positive adolescent reproductive health benefits and behaviours. These findings about the behavioural change effectiveness of family life/sex education programmes are virtually identical to findings in other sub-Saharan countries, including Ghana and Ethiopia. Impact evaluations of such programmes concluded that young people do not engage in sex earlier or in more frequent sexual intercourse. In some cases, the information and skills acquired by young people help them to delay the initiation of sexual activity (Gachuhi 1999; USAID 2002; Karim, Magnani et al. 2003; Bearinger, Sieving et al. 2007; Joyce, Askew et al. 2008).

Another barrier is that those working with preadolescents may not understand the relevance of the topic and may not know how to address it. Teachers, parents, and other community leaders are often reluctant to discuss sexuality with young people. Teachers are not accustomed to interacting with students in the ‘participatory’ methods these programs require.

However, there are age-appropriate curricula available for standards 1 ï 5. These deal with building basic skills such as self-esteem, problem solving, assertion, and negotiation that are useful to young learners in their everyday lives. Rather than dealing explicitly with sexuality, such curricula open up discussions about relationships between men and women, family roles, and stigmatization of those
affected by HIV/AIDS. At slightly older ages (e.g. standard 6), curricula can begin to build group norms of abstinence, monogamy, and safe sex (USAID 2002).

Several studies have shown that parents in sub-Saharan Africa are often reluctant to talk about relationships and sexuality with their children out of embarrassment, lack of accurate information, or fear that they will appear to condone adolescent sexual activity. Consequently, youth often cite peers and the media as their primary sources of information about sexuality. Unfortunately, these sources are often filled with erroneous information and myths. Research shows that many youth wish they could get information about sexuality from a trusted adult (USAID 2002). With parents unable or unwilling to provide this information, teachers are an obvious alternative for in-school youth. However, teachers may suffer the same shortcomings as parents, and require training and support to fulfil this role effectively.

In addition to a lack of comfort with the topic of adolescent sexuality, many teachers and students express frustration with an already overcrowded curriculum (USAID 2002). Many teachers also lack the confidence and training to use participatory methodologies, continuing to lecture rather than allow students to discuss and practice skills-building (Gachuhi 1999). Teachers will only be effective change agents if they have dealt with their own views of adolescent sexuality and attitudes towards those infected by HIV. Training must also address trainees’ own vulnerability to HIV/AIDS and acknowledge how HIV/AIDS has affected them (USAID 2002).

Implementation of sex education programmes in most countries is often weak or constricted to only one aspect of reproductive health e.g. HIV information but not prevention of STIs or pregnancy. To substantially reduce unintended pregnancies and transmission of HIV and STIs, a second challenge is to develop multi-pronged public-health approaches that not only affect individual behaviours, but also address social contexts and structural factors that act against safe sex. For example gender inequities that leave young people, especially girls, vulnerable to HIV infection have not been confronted. If adolescents wish to use condoms and seek reproductive health care, services may not be accessible to them.
2.6. Relevance of Life Skills Education in Kenya

Life Skills Education in Kenya was an approach initiated following positive outcome and experiences shared by other countries in Africa where outcomes were developing encouraging results. Many children today live in circumstances that make them vulnerable and limit their choices and potential. Life Skills Education was designed to help children copes better with the happenings of day to day challenges. Clare Hanbury (2008) observes that Life Skills Education, should help children to make better choices. Grace Ngugi, an LSE expert at the Kenya Institute of Education states that Life Skills Education in Kenya is becoming more relevant to children in preparing them for future responsibility and dealing with day to day experiences.

As highlighted above and in context with the trends and developments in Kenya today, the Adolescent girl in Kenya remains just as exposed to vulnerable situations that need Life Skills knowledge and understanding. The relevance of LSE in Kenya is similarly growing over the years due to dynamic changes and trends in society and therefore remains a crucial development of our children in society.

Today society has gone silent on very important topics like puberty, sexuality just to mention a few. Life Skills comes in to bridge this gap and emphasize on the formative stages of life that determine and shape one’s future. While Life Skills Education at school continues, it is important to mention that parallel developments with the child at the home environment strongly supplement the desired. The troubled social concerns raised daily in the media and places of worship point at the missing link at the formative stages. It is therefore paramount that the implementation of Life Skills Education will contribute greatly to all through Education.
2.7. Theoretical Framework

Eisenhart (1991) described a theoretical framework as a structure that guides research by relying on a formal theory constructed by using an established, coherent explanation of certain phenomena and relationships. The conceptual framework is further described by Eisenhart (1991) as a skeletal structure of justification rather than a skeletal structure of explanation. This structure is based on either formal logic or experience. As such it consists of an argument which can incorporate differing points of view and which ends in the articulation of a rationale for the adoption of some ideas or concepts in favour of others. This provides guidance in data collection and analysis. Eisenhart (1991) notes that Crucially, the conceptual framework is an argument that the concepts chosen for investigation or interpretation and any other anticipated relationships among them, will be appropriate and useful, given the research problem under investigations.

2.7.1 Problem Behaviour Theory

Jessor & Jessor (1977) recognise that adolescent behaviour (including risk behaviour) is the product of complex interactions between people and their environment. Problem behaviour theory (PBT) is concerned with the relationships among three categories of variables. The first category, the personality system, involves values, expectations, beliefs, and attitudes toward self and society. The second category, the perceived environmental system, comprises perceptions of friends' and parents' attitudes toward behaviours and physical agents in the environment, such as substances and weapons. The third category, the behavioural system, comprises socially acceptable and unacceptable behaviours. PBT is widely used theory to explain deviant behaviour in adolescents.

In PBT, and the three interacting system, problem behaviour is defined as that which departs from social norms of society and causes social control response from society, this is under the behaviour system.

In this model, negative reproductive health outcomes are conceptualized to be as a result of a dynamic interaction of environmental and individual factors, in which peers, parents, and other social influences interact with individual vulnerabilities to promote pre-marital sex. For example, some adolescent girls may be primarily
influenced to pre-marital sex by media presentations that normalize or glamorize sex, while others may be primarily influenced by family members or friends who engage in irresponsible sex or hold attitudes and beliefs supportive of this. These social influences are likely to have the strongest impact on those adolescent girls with poor social and personal competence skills, and together these factors may lead to certain psychological vulnerabilities such as low self-esteem, social anxiety, and psychological distress. The more risk factors that an individual has, the greater the likelihood that she will engage in pre-marital sex.

In summary, PBT brings out the fact that all behaviour is a result of person-environment interaction, reflects a ‘field theory’ perspective in social science (Lewin 1951)

### 2.7.2 Social Learning Theory

The social learning theories of Rotter and Bandura reflect and are derived from these views. Bandura’s social learning theory (SLT), which has recently been labelled social cognitive theory (SCT) holds that behaviour is determined by expectations and incentives:

i) **Expectations may be divided into three types**

a) Expectancies about environmental dues (that is beliefs about how events are connected i.e. about what leads to what).

b) Expectations about the consequences of one’s own actions (that is opinions about how individual behaviour is likely to influence outcomes). This is also termed outcome expectations.

c) Expectancies about one’s own competence to perform the behaviour needed to influence outcomes. This is termed efficacy expectation (i.e self-efficacy^3).

ii) **Incentives.**

Incentives are defined as the value of a particular outcome. The outcome may be health status, physical appearance, approval of others, economic gain etc.

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^3 Self efficacy: People are more likely to engage in certain behaviors when they believe they are capable of executing those behaviors successfully. This means that they will have high self-efficacy. In layman's terms self-efficacy could be looked as self confidence towards learning
The social cognitive theory or SLT has made at least two contributions to explanations of health related behaviour that were not included in the Health Belief Model (HBM). The first is the emphasis on the several sources of information for acquiring expectations particularly on the informative and motivational role of consequences. Rotter adds that a second contribution of SLT is the introduction of the self-efficacy (efficacy expectation) as distinct from outcome expectation. Outcome expectation (defined as a person's estimate that a given behaviour will lead to certain outcomes) is quite similar to the HBM concept of 'perceived benefits'.

Efficacy expectation is defined as the conviction that one can successfully execute the behaviour acquired to produce the outcomes. The distinction between outcome and efficacy expectations is important because both are required for behaviour.

Bandura Albert a leading proponent of the social learning theory illustrates the relations of efficacy expectations and outcomes as follows:-

PERSON  \[\rightarrow\] BEHAVIOUR  \[\rightarrow\] OUTCOME

\[\uparrow\]

Efficacy Expectations  \[\rightarrow\] Outcome Expectations

Diagram 1.: Relationship between outcomes and efficacy expectations in behaviour.
Source: Bandura A. 1977

Emerging out of Bandura’s SLT is efficacy theory (1997). He saw outcomes expectancy as the individuals judgement that a certain behaviour will lead to a certain and desired outcome. He defined self efficacy as the belief that one can successfully engage in a behaviour that is required to produce a desired outcome.

SLT stresses the importance of attending to and modelling behaviours, cognition (eg attitudes and beliefs) and emotions of others. SLT sees an interactive process between cognitive, behavioural and environmental influences (Ward and Gryczynski, 2009). Bandura observes that there are four requirements for learning and modelling behaviour. These are Attention, Retention, Reproduction and Motivation. Attention to modelling events in the environment and the characteristics of the observer to attend to those events (emotional, perceptual set and arousal level). Retention, which is the cognitive component involving remembering what one observed, coding, organizing and rehearsing it at the cognitive level. Reproduction or the ability to reproduce or copy the behaviour which includes observing and self reproducing the
behaviour and feedback of the accuracy of that reproduction and lastly motivation or behavioural consequence that justifies wanting to adopt the behaviour which includes reinforcement.

Ormrod (1999) identifies that social learning theory focuses on the learning that occurs within a social context. It considers that people learn from one another, including such concepts as observations learning, imitation and modelling.

The General principles of social learning theory show that:-

i) People can learn by observing the behaviour of others and the outcomes of those behaviours.

ii) Learning can occur with a change in behaviour.

iii) Cognition plays a role in learning (i.e. awareness and expectations of future consequences or punishments can have a major effect on the behaviour that people exhibit).

iv) Social learning theory can be considered a bridge between learning theories and cognitive learning theories.

In summary and in light of the research variables educational implications of social learning theory play a key role in this study. Bandura states that students often learn a great deal simply by observing other people. He adds that describing the consequences of behaviour can increase the appropriate behaviours and decrease inappropriate ones. He notes that teachers and parents must model appropriate behaviours and take care that they do not model inappropriate behaviour.

Social Learning Theory can be used to explain the development of deviant behaviour. Theoretically, if an individual never observed this behaviour, then such behaviours would never be learned. SLT on the other hand has its limitation, with respect to explain certain behaviours learned under certain conditions and an example is a child who commits a crime without being involved or seen such a crime before. This is however limited in extend in which it occurs.
2.8 Conceptual Framework

In light of the theoretical framework, the illustration below aims at bringing out the linkages between the different factors that influence/affect the behaviour or outcome. In the three boxes A, B & C. In box A, we see the person (adolescent girl in the case of the study) who has values, beliefs and expectations. In this context she operates in an environment which influences her expectations, desires of herself. Likewise her parents, peers and even teachers have expectations of her. In so doing we see the linkage between the individual and the environment/society. This linkage produces outcomes or behaviour which are either acceptable or not acceptable in society.

This link is evident in both Social Learning Theory and Problem Behaviour Theory since they both are looking at what influences the outcomes of one’s behaviour and in this case outcomes relating to reproductive health. This study aims at analysing the role of LST and how it contributes/influences the outcomes without changing much in the environment. LST therefore comes in at the individual and social setting level and this study will look at what effect it has on the outcome.

Nicholas Walliman’s (2001:121) states that ‘In casual statement, which describe what is sometimes called a “cause and effect” relationship, the concept or variable that is the cause is referred to as the “independent variable” (because it varies independently) and the variable that is affected is referred to as the “dependent variable” (because it is dependent on the independent variable). The influencing aspect in the cause and effect relationship is the intervening variable.’
PERSON + ENVIRONMENT = OUTCOMES LINKAGE

A
(PERSON)
(Independent Variables)

B
(ENVIRONMENT)
(Intervening Variables)

C
(OUTCOME)
(Dependant variable)

Values
Age
Belief
Religion
Expectations
Education
Attitude

Social Setting
Social Learning
Perceptions of
Parents/Guardians
Other Physical
agents in
environment
Peer pressure

Effective
communication
Decisiveness
Self Esteem
Confidence
Creative thinking
Problem solving
Coping
Self Management

Diagram 2 - Conceptual Framework
CHAPTER THREE: RESEARCH METHOD

3. Introduction

The chapter describes the methods that were used in carrying out this study. This included a description of the study area, the study population and design, data collection procedure, data management and analysis. The research method used questionnaires to obtain information from the girls attending public schools in Kibera.

This section focused on describing the course of action taken towards a valid solution to the problem. It is divided into the following sections. Study design adopted, study area, population and sampling approach, data collection method, unit of analysis and data analysis.

3.1. Study design.

This study used the descriptive design, pointing at a qualitative approach. It aimed at understanding the influence of LSE on health behaviour and outcomes through interviews conducted using self-administered questionnaire.

The interviews questions comprised of a combination of open and closed ended questions that focused on specific understanding of the research population bearing in mind the research questions and area of study. Due to the descriptive nature of this study, the collection of information was through primary data from the respondents. The samples from the formal/public secondary schools, was randomly selected aiming at drawing a small and manageable sample from the population.

The targeted sample size was 10% of the girls population attending formal schools which allowed for an in-depth analysis of each question asked.

Observation method was also utilized to assess the level of confidence especially in completing the questionnaire.
3.2. Study Area

Kibera is found in Langata district in Nairobi county. It is one of the most densely populated, low-income, informal urban settlements in Kenya. It is estimated that more than 600,000 people (of whom half are under the age of 15) live in the area encompassing roughly four square kilometres on the edge of downtown Nairobi (Wood, Maxwell et al. 2006). Most of the houses in Kibera had no sanitation, running water or electricity. The community is home to various Kenyan ethnic groups, in addition to the Nubians (a predominantly Muslim group originally from Sudan) who claimed land tenure rights to the settlement. Kibera also known as Kibra is known for collective violence, usually involving unemployed young people. The settlement is divided into thirteen villages, most of were dominated by a particular ethnic group. Many families survived through micro-businesses run primarily by women, such as hawking and selling. They additionally seek employment for low cadre jobs in the neighbourhood and also trek to industrial area for casual jobs including construction sites.

VILLAGES IN KIBERA

Map 1. The thirteen villages in Kibera
Source: Map Kibera Project. (www.mapkibera.org)
In Langata district, there were three categories of secondary schools. These were the public, private and non formal schools.

**Secondary Schools**

<table>
<thead>
<tr>
<th>Type of School</th>
<th>Girls</th>
<th>Boys</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Schools</td>
<td>1124</td>
<td>1704</td>
<td>2828</td>
</tr>
<tr>
<td>Private Schools</td>
<td>1334</td>
<td>2407</td>
<td>3741</td>
</tr>
<tr>
<td>Non Formal Schools</td>
<td>1019</td>
<td>1082</td>
<td>2101</td>
</tr>
<tr>
<td><strong>TOTAL FOR ALL</strong></td>
<td><strong>3477</strong></td>
<td><strong>5193</strong></td>
<td><strong>8670</strong></td>
</tr>
</tbody>
</table>

Table 1: Secondary Schools Enrolment Data – May 2012.

Poverty and a lack of access to formal education and health services in Kibera are having a dramatic impact on young people's sexual and reproductive health. In a context where abortion is illegal, there are high levels of unsafe termination of pregnancies. HIV and AIDS are serious issues for Kibera residents, and are underpinned by acute poverty. 'Survival' sex work and inter-generational sexual relations (often resulting in early marriage) are common (Wood, Maxwell et al. 2006).

In this time and age when media provides for information for adolescents, this study also touched on the aspects of media in Life Skills knowledge exchange especially with reference to reproductive health information and understanding oneself.

### 3.3. Target Population and Sampling Procedure.

The target population for this study was adolescent girls attending public formal schools in Kibera, in Nairobi. The girls selected, were girls who attended formal public school under the 8-4-4 system which had the LSE component in the curriculum through which they have been exposed to through the curriculum. These schools in Kibera mainly comprise of formal- public, public informal and private schools. This study focused on the formal public schools based on the information provided by the district education office in Kibera.
A sample of 72 adolescent girls from formal public secondary schools in Kibera within the age bracket of 15 – 19 years was sampled, targeting a minimum 10% of girls in Kibera. Based on the schools, the girls in the category of adolescents (15 – 19 years) were randomly selected from schools using simple random sampling technique. The sample selection was based on the following criteria/considerations:-

a) Girls secondary schools in Kibera
   This was from table 1 above where the total population of girls in public secondary schools was 1124 girls as at May 2012 in Langata district with approximately 720 girls from Kibera. Due to the limited number of public secondary schools in Kibera, all the public secondary schools were considered part of the sample with a minimum target of two.

b) Where a school had more than one stream per class, the allocation per class was shared amongst the two streams. This therefore meant that in each level eg Form1, we targeted six students in total and this would further be divided between the two streams giving three for each stream.

c) The class register was used where the first three girls in the registered were picked as respondents. The availability of the student was a key criteria in the selection. The type of school and age brackets remained 15-19 years. In cases where Nos 1-6 were absent, the next girl available in the class register was selected as part of the sample.
3.4. Data Collection Methods

This study focused on primary data that was collected using a researcher administered questionnaire with both open & closed ended questions. Questionnaires were easy to administer and they helped in standardising the responses. The questionnaires were designed to draw out socio-demographic information, knowledge and practices regarding reproductive health and LSE. The questionnaire adopted the Likert- type scale of evaluation/assessment.

3.5. Unit of Analysis

The unit of analysis was the main entity in the study. It was the specific element / component under study. It was the "what" or "who" that was under research. In this study the unit of analysis was the individual adolescent girl, who is attending a formal public school and aged between 15 to 19 years.

3.6. Data Analysis

Quantitative and Qualitative data from questionnaires was entered using Microsoft Excel. The data was then sorted and analysed based on the study objectives. Descriptive statistics such as frequency distributions, percentages and means were used to describe the sample. The outcomes were presented in charts and tables. Ethical consideration and integrity was upheld in data analysis and presentation.
CHAPTER FOUR: STUDY FINDINGS

4. Introduction

This chapter reports on the findings of the study. It looked through the core Life Skills components and linked them to the objectives of the study. These key core Life Skills in this study included:

- a) Self awareness
- b) Critical thinking
- c) Decision making,
- d) Effective communication
- e) Stress Management
- f) Empathy
- g) Problem Solving
- h) Interpersonal relationship
- i) Coping with emotion

In general the study was designed to assess the influence of life skills education on reproductive health behaviour of adolescent girls in the informal settlement of Kibera in Nairobi, Kenya.

In exploring the influence of LSE on the reproductive behaviour of the adolescent girl in Kibera settlement in Nairobi, the study also investigated how exposed the girls were and how much they have understood based on the benefits of LSE through application.

The study went further to assess the benefits LSE has made in dealing with the day to day challenges that the adolescent girl faces in her growth.

Lastly, the study looked at the available sources of information and how these sources of information pause as a challenge to this age-group.
4.1. Demographic Data

The tables and diagrams below illustrate the general characteristics of the Adolescent girls included in the study.

Table 2: Age distribution of respondents

<table>
<thead>
<tr>
<th>Age of respondents (years)</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 years</td>
<td>12</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>16 years</td>
<td>20</td>
<td>28</td>
<td>45</td>
</tr>
<tr>
<td>17 years</td>
<td>32</td>
<td>44</td>
<td>89</td>
</tr>
<tr>
<td>18 years</td>
<td>8</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>19 years</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>72</strong></td>
<td><strong>100%</strong></td>
<td></td>
</tr>
</tbody>
</table>

A total of 72 respondents were interviewed during the study. Highest percentage of respondents was of 17 year olds (44%) and lowest percentage was 19 year olds (0).

Chart 1: Age distribution of respondents

The findings confirmed that most of the students interviewed were between the age of 15 and 19 years with a majority of them between 15 and 18 years, mainly between form 2 and 3.
Chart 2: Religion of respondents

Among the respondents 61% were Catholic, 11% Protestants, 11% Muslim, 11% African Tradition Religion and 6% Others.

Chart 3: Education level of respondents

The respondents comprised of form 1 to form 4 girls, with 56% in form 2, 33% in form 3 and 6% in form 1 and 4 respectively.
In family living status, the study found that 39% lived with a mother only, 28% with both parents and 33% with neither parents.

Chart 5: Family Size

27% of the respondents hail from a family of 4 children, 23% from a family of 3 children and 5 children respectively, 16% from a family of 6 children and 11% from a family of 2 children. No respondent was an only child.
Among the respondents 44% were first born, 17% second born, 11% third born, 22% 4th born and 6% were other born in their families.
4.2. Knowledge of Basic Reproductive Health

The study assessed the level of the respondents’ knowledge of basic reproductive health by asking simple questions on the Adolescence stages relating to reproductive health, signs and changes.

Chart 7: Knowledge of Basic Reproductive Health

The findings as exhibited in Chart 7, revealed that 100% of the population had both the basic knowledge and general idea of Adolescence with ability to understand that hormonal changes affect the emotions/feelings among other signs. This revelation indicated a high level of self awareness in regards to the changes linked to the puberty stage of life. The recognition and understanding of "self" was similarly related to understanding and recognizing other changes or differences that take place in their bodies and consequentially affects the kind of decision made, approaches we opt for to solve problems, how we communicate etc.

In the second part of the knowledge assessment, the study focused at understanding if the girl understood the changes/differences in Adolescence or puberty and how well. In Chart1, the findings indicated that as compared to basic understanding of what adolescence was, 6% of the population under study was not sure if puberty started earlier in girls nor that menstruation indicated that the girl’s body was mature and capable of having a baby.
The study found that 50% of the study population strongly disagree and 33% disagree with the engagement of premarital sex among the adolescents. On the contrary 11% strongly agree with premarital sex among the adolescent while 6% were not sure. In Chart 1 below, findings confirmed that understanding of Adolescence was high with 100% of the respondents accurately able to relate with the changes and signs of puberty.

4.3. Peer Influence

In the first part of the study on peer influence, the study found that the confidence level of the population under study was high when dealing with friends in relation to decision making and interpersonal relationships.

As depicted in Chart 8 below an average of 88% affirmed that they were confident and very confident in managing their relationships with friends and 89% were confident and very confident in making decisions that affected their interpersonal relationships.

The study further found that the Adolescents were not as confident in resisting pressure when there is persistent pressure exerted on them. 61% indicated that they were confident and very confident when under persistent pressure to make decision, while 17% did not know their confidence level when dealing with persistent pressure from a close friend.
The study found that when the respondent was pressurized to make a decision by friends, the number of confident adolescent decreased. The trend presented a scenario where the Adolescent's confidence dropped while under pressure but was very high when not under pressure especially from friends.

4.4. Self Esteem, Feelings and Relationships

The study revealed that Self Esteem was very high. A positive Self Esteem towards self was evident across the respondents. This was closely related to self awareness and managing other emotional skills like feelings and empathy.
Chart 9: Positive attitude towards self.

Positive attitude towards self was assessed in the study. The adolescent girls were asked how positive they were towards themselves and amongst their peers.

The study found that 29% & 65% agreed and strongly agreed respectively to have a positive attitude towards themselves, with a minimum number (6%) of students portraying low Self Esteem.

The study further found that the respondents compassion for others was very high. In seeking to find the students reaction in a situation where a fellow student was being harassed. The findings depicted concern, empathy and emotional skills. 53% indicated that they would intervene and personally stop the harassment while 35% wanted to stop it but did not know how to do so. 12% preferred to get someone else to intervene. These three findings indicated a strong sense of empathy and emotional involvement in day to day life.
Chart 10: Reaction to witnessed harassment.

Reaction to harassment which is defined as calling names, touching etc, was an aspect in the study that was assessed. The adolescent girls were asked about their reaction towards harassment.

![Bar Chart]

In personal relationships where expression of opinions and feelings amongst peers was assessed, the study revealed that 66% agreed and strongly agreed to their high capability to openly express themselves. This reflected a high level of interpersonal communication at personal relationships.

The study further found that, when it dealt with openly expressing opinion with peers, the levels of communication and general social skills were lower than in interpersonal relationships. The findings on expression of opinion among peers also represented a 17% of respondents not sure if they openly expressed their opinion with peers.
4.5. Sources of Information

The study revealed the available sources of information accessible by the sample population.

As depicted on Chart 4, the print and electronic media were found to be widely available to the sampled population with 83% able to access the newspapers and magazines at home, 94% able to access the radio, 83% watch the television at home and 28% with no access to the internet at home.

Important to note was that 72% of the study population did not have access to the internet at home.

Chart 11: Sources of information.
4.6. Preferred Source of learning and Information on Reproductive Health

The study revealed that when looking into learning and information acquisition on reproductive health, 22% of the study population preferred Video/ DVD, 17% preferred magazines, internet and cinema respectively while 28% preferred other sources of learning.

In learning new skills, the study revealed that 100% agreed to take any opportunity to learn new life skills. Additionally, the study observed that consultation and seeking advice on difficulties in reproductive health related decisions was agreed to by 22% while 56% agreed and strongly agreed respectively as illustrated in Figure10 below. On the contrary the study revealed that 17% and 6% disagreed and strongly disagreed respectively on consulting about reproductive health decisions.

The study found that in seeking the opinion of older family members on matters regarding reproductive health, 72% always respected such opinions of older family members, 17% sometimes respect such opinions, while 6% never respect the opinion of older family members.

**Chart 12: Consultation on reproductive health decisions.**
4.7. Stress Management

The study focused on understanding how the population managed and dealt with stress especially in relationships. The study found that 28% agreed and 28% strongly agreed and found it comfortable to deal with stress in their relationships with peers. 17% were not sure about their ability to deal with stress in their relationships, 22% disagreed and 6% strongly agreed when looking at their ability to deal with stress in their relationship as illustrated in Chart 13 below.

When dealing with feelings and emotions, 50% felt that discussing with friends helped the best in handling feeling of depressions while 22% preferred watching TV. 28% found help in other activities

Chart 13: Stress Management.
4.8. Career Choice

Chart 14: Career Choice.

The adolescent girls were asked about their future career plans. Options given varied from self employment to white collar jobs.

In the career prospects of this study population, the study revealed that 24% would like to be Doctors, 18% Engineers, 24% Teachers/Lecturers, 6% Business people and 29% preferred other careers. The selection of careers amongst the respondent reflected positive prospects in the future similar to any typical setting. A lot of interest was on professional careers with a minimal percentage looking at self employment. Critical thinking of their future and ambition is active.

In conclusions the findings reported in this chapter depicted finding of the study pointing towards the areas in life skills education in relation to reproductive health behaviour and outcomes that needed to be given more focus. This is to build on the core life skills components that include support creative thinking, critical analysis, coping with emotions and stress.
CHAPTER FIVE SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5. Introduction

This chapter discusses the summary of the findings, conclusion of the study and gives recommendations based on the findings as presented in chapter four.

5.1. Summary of Findings

This study confirmed the important role that Life Skills Education plays especially to the adolescent girl while in school and after. It emphasized that Adolescence is a stage in life where the foundation of the future is laid and therefore needs the necessary attention.

This study focused on LSE in association with reproductive health. Life skills Education is very wide and this study basically centred on understanding if the adolescent girl in Kibera has been exposed to Life Skills Education and Knowledge in school. The study also focused on understanding if the adolescent girls in Kibera had benefitted from the Life Skills Education being taught in school and how this training has been put into practice in the day to day living in society. Lastly the study focused on understanding the hindrances and challenges the adolescent girls faced while learning Life Skills in school and beyond in light of the available sources of information.

In today’s society, the adolescent girl is faced with multiple challenges in a fast growing and dynamic world. Changes in society today call for preparedness and advancement in knowledge in order to tackle the day to day challenges and experiences. In the past, the scenarios were less complex since community setting provided for a favourable environment with minimal challenges supported by set activities for the youth.
The study found that LSE is being taught meaning the adolescent girls of Kibera have been exposed to LSE while in school. It further found that the teachers have also been exposed to training in LSE hence able to teach the adolescents on Life Skills and provide the necessary guidance. The study found that whereas the different schools reflected different levels of commitment towards Life Skills Education. The underlying exposure to Life Skills was evident.

Life Skills in relation to reproductive health was well understood with knowledge on reproductive health indicating the benefit of such education and knowledge.

The study found that the levels of confidence in social skills/interpersonal relationships with peers was very high, however when dealing with situations where pressure was exerted, the levels of confidence tended to drop. In society, it is known that majority of social behaviour that is negative is due to an aspect of peer pressure. The study clearly established that the ability to say "No" or negotiate out of a situation where there is peer pressure could not be managed well by the respondent.

Similarly the study established that expressing oneself at interpersonal relationship level was very admirable while not as high when expressing one’s opinion to peers at larger groups. The study also found that emotional skills were very high, e.g. when dealing with empathy, concern, managing feelings and emotions. The contrary applied to a situation where expression of opinions/emotions beyond interpersonal levels applied.

The study revealed that the available sources of information for the respondents, was vast. One of the main challenges was the overwhelming information available through various media some of which may be reliable and others not. These pauses a challenge especially when we found that access to the different types of media was easily available (especially at home) making it a tricky situation with all the available information, trends and fashion.
The study found that stress management is well understood by the respondents and dealing with stress has different options especially in interpersonal relationships. Managing stress cuts across social, emotional and thinking skills. In this component of the study, it was evident that more exposure when it comes to dealing with stress management in relationship was inevitable. The confidence levels and acceptance to the ability to manage stressful situations was relatively low compared to the other parts of the study.

The study confirmed that there was keenness to learn more on Life Skills. This confirmed the relevance and importance of Life Skills in the ordinary life of an adolescent girl in Kibera. On the contrary, the study found that there is still a need to increase the importance of consultation especially on reproductive health matters by the respondents considering the fact that most challenges of these age groups relate to reproductive health issues. Older members of family were still highly regarded as points of reference for reproductive health and this relates back to the traditional African Society where older family members especially female relatives played a great role in reproductive health matters consultation for the girl child.

5.2. Conclusion and Recommendations

Life skills Education encompasses various aspects of growth that are required in the day to day life of school going children for today and in the future. The findings indicated that great milestones of LSE have been achieved and benefitted girls however it also brings out the influence of media on LSE and the dynamic changes of society. This study and other studies have confirmed that actions and challenges that the adolescent girls’ face during adolescence, shape her future and prepare her socially, emotionally and critically in order to face the day to day challenges of life.

This study recommends that more emphasis should be given in the implementation of Life Skills Education for students not only to meet the curriculum requirements but indeed prepare the girl for future life in context with the changing society. This is to ensure that a proper foundation is put in place for the growth of adolescents and shape a well prepared youth for future responsibilities.
The implementation of Life Skills Education especially as currently executed may need further intervention and attention to capture the desired levels from these studies just as the other examinable subjects. More integrated approaches and creative learning methods to help the students benefit more and relate to day to day experiences

Lastly emphasis on monitoring of the implementation of the Life Skills Education programs should be conducted on frequent basis (peer to peer based) to keep in tandem with the ongoing changes. Additionally, due to attraction to print and electronic media, an investment in school publications/illustrations, addressing thematic areas of Life Skills eg in short DVDs/posters in the children magazines, flyers among others would greatly impact the Adolescent.
References:


Bandura, A 1977. Self efficacy; Towards a unifying theory of behaviour change, psychological review 84: 191-250.


WHO (2004). Promoting Mental Health; concepts ;emerging evidence; practice. Geneva; WHO


Internet Sources:


Life Skills Module

Map Kibera Project Ė Maps and Statistics
Mapkiberaproject.yolasite.com/maps-and-statistics-php
Annexes:

Annex 1 - Interview Introduction and Consent

Hello. My name is ............................ and I am Masters Student at the University of Nairobi, studying rural sociology and community development. I am conducting research about the influence of life skills education on social and emotional reproductive health behaviour of adolescent girls in Kibera. I have selected you as a respondent due to the importance of this age group i.e. 15-19 years regarding their social and emotional reproductive health wellness.

This information will help me contribute to policy and strategies with the relevant stakeholders. The questionnaire usually takes about 30 minutes to complete. Whatever information you provide will be kept confidential and will not be shared with anyone.

Participation is voluntary, and if you find any question that you do not wish to answer, please let me know and we will proceed to the next question. I however hope that you will participate since your views are important.

Signature of interviewer:....................................... Date:................................................

Respondent agrees to be interviewed |___|

Respondent does not agree to be interviewed |___|
Annex 2 – Research Questionnaire

Questionnaire serial number

Date of interview:  __/__/ day  /__/month /__/__/__/Year

**DO NOT** put your name on this survey. Your answers will be kept secret.  No one will know how you answered these questions.

<table>
<thead>
<tr>
<th>N°</th>
<th>QUESTIONS</th>
<th>ANSWERS</th>
<th>SKIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>SOCIAL DEMOGRAPHIC CHARACTERISTICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>How old are you? <em>(Record age in years)</em></td>
<td>Record number of years ____________</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>99 = DON'T KNOW</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>What is your religion? <em>(Optional)</em></td>
<td>1 = Catholic</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Protestant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Muslim</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = African Traditional Religion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Other (Specify) ____________________________</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Which class are you?</td>
<td>1 = Form 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Form 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Form 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Form 4</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>With whom do you live with <em>(parents)</em>?</td>
<td>1 = Living with both parents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Living with father only</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Living with mother only</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Living with neither parents</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>How many children are you in your family <em>(children only)</em></td>
<td>No of Girls [___]</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. Of Boys [___]</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>What born are you in the family?</td>
<td>1 = 1st</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = 2nd</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = 3rd</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = 4th</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Others (Specify) ..................</td>
<td></td>
</tr>
</tbody>
</table>
### KNOWLEDGE ON BASIC REPRODUCTIVE HEALTH

Read each question. Carefully check the one answer that fits best.

<table>
<thead>
<tr>
<th>N°</th>
<th>QUESTIONS</th>
<th>ANSWERS</th>
<th>SKIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Adolescence is a stage in life that is most critical in shaping one's future?</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>As boys and girls' bodies change during puberty, hormones also change their feelings to change</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Girls usually start puberty at an earlier age than boys.</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>When monthly periods (menstruation) start, it means that a girl's body has matured &amp; capable of having a baby.</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
</tbody>
</table>

### PEER INFLUENCE

Read each question. Carefully check the one answer that fits best.

**A.** It is a Sunday afternoon, and you have been putting off your chores and homework all weekend. You have got enough work to fill the rest of the day. Your best friend invites you to go to a movie. She says the chores and homework can wait. If you did NOT want to go with your friend:

<table>
<thead>
<tr>
<th>N°</th>
<th>QUESTIONS</th>
<th>ANSWERS</th>
<th>SKIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>How confident are you on the answer to give your friends on your stand following her proposal?</td>
<td>1 = Not confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Somewhat confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = I don't know</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Very confident</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>How confident are you to refuse to the proposal above?</td>
<td>1 = Not confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Somewhat confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = I don't know</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Very confident</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>How confident are you that you could resist if your friend keeps pressurizing you?</td>
<td>1 = Not confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Somewhat confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = I don't know</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Confident</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Very confident</td>
<td></td>
</tr>
</tbody>
</table>
**B.** Your parents/guardian have forbidden you to go to a part of the estate/area you live in, that they think is dangerous, because there is crime, lawlessness and drug use in that area. Some of your friends want you to go there with them. They say it is not **that bad** and that you can have a good time there. They say you are a coward if you don't go. If you do **NOT** want to go with your friends:

<table>
<thead>
<tr>
<th>Nº</th>
<th>QUESTIONS</th>
<th>ANSWERS</th>
<th>SKIP</th>
</tr>
</thead>
</table>
| 14.| How confident are you, about what to tell your friends?                   | 1 = Not confident  
2 = Somewhat confident  
3 = I don't know  
4 = Confident  
5 = Very confident |        |      |
| 15.| How confident are you to refuse to the proposal above by your friends?    | 1 = Not confident  
2 = Somewhat confident  
3 = I don't know  
4 = Confident  
5 = Very confident |        |      |
| 16.| How confident are you that you could resist if your friend keeps pressurizing you? Without losing him/her as a friend. | 1 = Not confident  
2 = Somewhat confident  
3 = I don't know  
4 = Confident  
5 = Very confident |        |      |

This Section asks you to say whether you agree or disagree with a set of statements. Please read each statement, then indicate whether you **Strongly Agree, Agree, are Not Sure, Disagree, or Strongly Disagree** by circling the answer you want.

<table>
<thead>
<tr>
<th>Nº</th>
<th>QUESTIONS</th>
<th>ANSWERS</th>
<th>SKIP</th>
</tr>
</thead>
</table>
| 17.| If your friends want you to do something that you think might not be safe, you should at least try it. | 1 = Strongly Disagree  
2 = Disagree  
3 = Not Sure  
4 = Agree  
5 = Strongly Agree |        |      |
| 18.| To keep your friends, you should go along with most things your friends want you to do. | 1 = Strongly Disagree  
2 = Disagree  
3 = Not Sure  
4 = Agree  
5 = Strongly Agree |        |      |
| 19.| Teenagers should resist pressure from their friends to engage in sexual activity, including pre-marital sex | 1 = Strongly Disagree  
2 = Disagree  
3 = Not Sure  
4 = Agree  
5 = Strongly Agree |        |      |
<table>
<thead>
<tr>
<th>No.</th>
<th>Questions</th>
<th>Answers</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.</td>
<td>I take a positive attitude towards myself</td>
<td>1 = Strongly Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Not Sure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>I wish I would have more respect for myself from my peers</td>
<td>1 = Strongly Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Not Sure</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>I feel that I am a person of value amongst my peers</td>
<td>1 = Strongly Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Not Sure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>How serious a problem do you think harassment of girls is in your school by other girls? (Harassment is hereby defined as calling them names and trying to touch them)</td>
<td>1 = Very serious</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Somewhat serious</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = I don't know</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Not very serious</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Not very serious at all</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>How serious a problem do you think harassment of girls is in your school by boys?</td>
<td>1 = Very serious</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Somewhat serious</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = I don't know</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Not very serious</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Not very serious at all</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Which of the following statements best describes how you would react if a female classmate in your school was harassing a fellow female student?</td>
<td>1 = I would not get involved.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = I would want to stop it, but I don't know how.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = I would get someone else to intervene.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = I would intervene and stop it myself</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>I am comfortable expressing my opinion and feelings in my personal relationships with my peers.</td>
<td>1 = Strongly Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Not Sure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>I believe that I am confident and value myself</td>
<td>1 = Strongly Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Not Sure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>I openly express my opinion at school to my peers</td>
<td>1 = Strongly Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = Disagree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Not Sure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
<td></td>
</tr>
</tbody>
</table>
## ACCESS TO MEDIA INCLUDING SOCIAL MEDIA.

Read each question. Carefully check the one answer that fits best.

<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Answers</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>Do you read a newspaper or magazine at home?</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Do you listen to the radio at home?</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Do you watch television at home?</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Do you have access to the internet at home?</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>If you were given an opportunity to understand about your reproductive</td>
<td>1 = Video/DVD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>health issues, which would be your preferred source of learning /</td>
<td>2 = Magazine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>information?</td>
<td>3 = Internet</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Cinema</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Others (specify)</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>I can manage stress in my relationships with female friends</td>
<td>1 = TRUE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = FALSE</td>
<td></td>
</tr>
</tbody>
</table>

### DIRECTIONS: This Section asks you to say whether you agree or disagree with a set of statements. Please read each statement, then indicate whether you **Strongly Agree (SA), Agree (A), are Not Sure (NS), Disagree (D), or Strongly Disagree (SD)** by circling the answer you want.

## SELF AWARENESS & CREATIVE THINKING.

Read each question. Carefully check the one answer that fits best.

<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>As an adolescent, I take advantage of any opportunity to learn new life</td>
<td>1 = Strongly Disagree</td>
</tr>
<tr>
<td></td>
<td>skills</td>
<td>2 = Disagree</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Not Sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
</tr>
<tr>
<td>36</td>
<td>As an adolescent I consult or seek advice on areas that are difficult to</td>
<td>1 = Strongly Disagree</td>
</tr>
<tr>
<td></td>
<td>handle especially in decision making in Reproductive Health issues</td>
<td>2 = Disagree</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Not Sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
</tr>
<tr>
<td>37</td>
<td>When I don’t agree with my friends/peers on a certain issue and we end up</td>
<td>1 = Strongly Disagree</td>
</tr>
<tr>
<td></td>
<td>in disagreement, many times I seek to resolve the matter and get it sorted</td>
<td>2 = Disagree</td>
</tr>
<tr>
<td></td>
<td>out.</td>
<td>3 = Not Sure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Agree</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
</tr>
</tbody>
</table>
### ATTITUDES AND BEHAVIOUR

Read each question. Carefully check the one answer that fits best.

<table>
<thead>
<tr>
<th>N°</th>
<th>QUESTIONS</th>
<th>ANSWERS</th>
<th>SKIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>38.</td>
<td>I like to voice my view in matters that are of great importance to me to my peers</td>
<td>1 = Strongly Disagree 2 = Disagree 3 = Not Sure 4 = Agree 5 = Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>39.</td>
<td>I can manage stress relating to relationships with my peers.</td>
<td>1 = Strongly Disagree 2 = Disagree 3 = Not Sure 4 = Agree 5 = Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>When you feel depressed, what helps you most?</td>
<td>1 = Discussion with friends 2 = Watching TV 3 = Sports 4 = others (specify)</td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>What do you want to be when you grow up?</td>
<td>1 = Doctor 2 = Teacher/ Lecturer 3 = Business-lady 4 = Engineer 5 = Housewife 6 = Pilot 7 = Others</td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>Do you respect the opinion of older family members on matters regarding reproductive health?</td>
<td>1 = Always 2 = Sometimes 3 = Never 4 = I don't Know</td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>Do you try hard to get along well with your friends?</td>
<td>1 = Always 2 = Sometimes 3 = Never 4 = I don't Know</td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td>Has anyone made sexual advances towards you?</td>
<td>1 = Relative 2 = Teacher 3 = Friend 4 = Stranger 5 = Others (specify)</td>
<td></td>
</tr>
<tr>
<td>45.</td>
<td>Do you think, premarital sex is good for adolescents?</td>
<td>1 = Strongly Disagree 2 = Disagree 3 = Not Sure 4 = Agree 5 = Strongly Agree</td>
<td></td>
</tr>
</tbody>
</table>

**THIS IS THE END OF THE QUESTIONNAIRE. THANK YOU FOR TAKING THE TIME TO ANSWER OUR QUESTIONS. I APPRECIATE YOUR HELP**
Annex 3 – Key informants Interview Guide

Name................................................... Date...................................................

School..................................................... Position....................................................

The focus of this exercise is to better understand how Life Skills Education has influenced reproductive health behaviour and outcomes in your school and community. Your input from this discussion will be documented in order to make improvements in implementation, policy development and strategizing better to support his age-group.

My aim is to understand the influence that LSE has had on the adolescent girls reproductive health outcomes.

Anything you share will be documented for purposes of this study only. No individual comment can be attributed to a particular person.

Your participation in this interview is completely voluntary. If you are in agreement the main areas of discussion are the following:-

a) To what extent have adolescent girls in Kibera been exposed to Life Skills imparted on them through LSE
   a. Is LSE a suitable approach to manage risky behavior outcomes?
   b. What other recommendations would you propose to LSE that would greatly influence reproductive health behavior outcomes

b) What challenges do the multiple sources of information present to LSE learning amongst the adolescent girls?

c) In implementing LSE, what would you do differently.
Annex 6 – Authorization for field work

UNIVERSITY OF NAIROBI
DEPARTMENT OF SOCIOLOGY & SOCIAL WORK

Fax 254-2-245566
Telex 22095 Varsity Ke Nairobi Kenya
Tel. 318262 Ext. 28167

P.O. Box 30197
Nairobi
Kenya

14th May, 2013

TO WHOM IT MAY CONCERN

RE: GLADYS K. ANYA - C50/8383/2001

This is to confirm that the above named is a bona fide M.A. student in the
Department of Sociology and Social Work. She has presented her project
proposal entitled: “Explore the influence of life skills education on
Reproductive Health Behaviour of adolescent girls in Kibera Slum in
Nairobi.”

Ms. Anya is required to collect data pertaining to the research problem
from selected organizations to enable her complete her proposal which is a
requirement of the Masters degree.

Kindly give her any assistance she may need.

Dr. Robinson M. Ocharo
Chairman, Dept. of Sociology & Social Work

cc. Prof. C. Nzioka
Supervisor