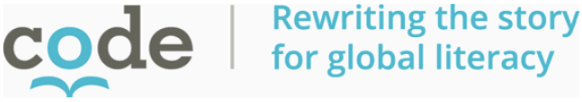

Context Matters
— RESEARCH GRANTS —

Leveraging coaching to improve sexual health literacy among teachers in informal urban settlements in Nairobi, Kenya

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Abstract

Kenyatta University, Jaslika and Dignitas collaboratively conducted action research to enhance sexual health literacy among upper primary school teachers in two Nairobi informal settlements. Recognizing the necessity for effective and inclusive sexual and reproductive health education (SRHE), the project investigated existing practices, identified teacher needs, and developed strategies to strengthen their capacity. Key findings revealed significant gaps in teacher knowledge, skills, and attitudes toward gender-equitable SRHE. Inadequate training, insensitive attitudes, and a lack of clear curricular guidance that addresses gender norms and power dynamics were identified as major challenges. Learners, particularly girls, faced challenges such as peer pressure, limited access to accurate information, and the impact of gender-based violence. The project implemented a coaching programme and engaged teachers in the co-creation of culturally appropriate and gender-sensitive SRHE resources. This approach

demonstrated effectiveness in enhancing teacher capacity and improving the quality of gender-equitable SRHE. The study emphasizes the critical need for comprehensive teacher training that addresses gender stereotypes and power dynamics, clear curricular integration of gender-equitable SRHE, the creation of safe and inclusive learning environments that are free from gender-based discrimination, and multi-sectoral collaboration with a focus on gender equality to effectively address the sexual health needs of adolescent girls and boys in these communities.

Key Words: adolescent sexuality, sexual and reproductive health literacy, sexual and reproductive health education (SRHE), gender responsive SRHE, teacher capacity, gender-based violence (GBV), urban informal settlements, gender norms, safe learning environments, action research

Contents

Introduction

From 2021 to 2024, a collaborative research initiative, supported by the CODE Context Matters Research Grant, brought together three Kenyan institutions — Kenyatta University, Jaslika, and Dignitas — to strengthen the capacity of teachers to deliver sexual and reproductive health education (SRHE) in ten primary schools within two Nairobi informal settlements: Huruma and Kawangware. Leveraging the unique strengths of each partner—Jaslika's expertise in SRH, gender, child rights, and participatory research methodologies, and Dignitas' proficiency in school leadership training and coaching—the project employed an action research approach to address critical SRHE delivery shortcomings. The research questions that guided this study were:

1. How do internal and external factors influence learners' SRH knowledge, attitudes, and behaviors in the informal settlements of Huruma and Kawangware?

   a. What are the sexual and reproductive health concerns of adolescents living and schooling in Nairobi's informal settlements?

   b. What policy measures has the Kenyan government instituted to address these concerns?

   c. What are the key barriers to implementing policy interventions?

2. What is the status of SRHE implementation in primary schools in Nairobi's informal settlements?

   a. What are the current methods and channels used for sexual and reproductive health education in selected schools in these settlements?

   b. What is the level of teacher preparedness in selected schools for delivering SRHE, including their knowledge, skills, and access to accurate information? What are the identified gaps in their knowledge and literacy skills related to SRHE, and how do these

gaps impact their ability to effectively teach this subject?

d. What are the current SRH literacy levels of the coaches supporting capacity development of teachers in the selected schools?

3. How can we improve teacher SRHL and SRHE delivery in these schools practically and sustainably?

This paper outlines the research methodology and process, demonstrating how the implementation of a Participatory Action Research (PAR) design helped to effectively navigate the challenges associated with SRHE research in resource-constrained contexts like Huruma and Kawangware. The presentation of key findings illuminates the barriers and opportunities encountered in teaching and learning SRHE, drawing insights from data collected to address the six core research questions, while situating these findings within the backdrop of both national policy contexts and the social, cultural and economic realities of Nairobi's informal settlements. The conclusion synthesises key emerging themes and proposes potential solutions for future interventions. A visual report documenting the research activities, alongside brief biographies of the research team, are appended to the paper for further context and transparency.

Research methodology

This study employed a Participatory Action Research (PAR) design, a methodology particularly well-suited for sensitive topics like Adolescent Sexual and Reproductive Health (ASRH). By fostering open dialogue and collaboration among researchers, teachers, and coaches, PAR effectively broke down the barriers to open communication surrounding these often-contentious issues. This collaborative approach minimized power imbalances, enabling shared learning and fostering innovation in classroom practices. Importantly, it empowered

teachers and coaches to actively identify emerging challenges and refine their teaching strategies in real-time.

Within the broad PAR framework, the study utilized a mixed-methods approach. Data sources included a semi-structured perception questionnaire, qualitative methods (interviews, focus group discussions, and classroom observations), and an evaluation of curricula and non-curricular materials used by schools for ASRH education. These methods were complemented by consultative meetings, participatory capacity development activities, and co-creation workshops integrated throughout the research process. This participatory approach empowered research participants (teachers and coaches) to:

- Express and analyze their own levels of sexual health literacy.
- Identify and address knowledge gaps in ASRH content.
- Co-develop innovative strategies for effectively communicating ASRH information to adolescent learners.

Study process

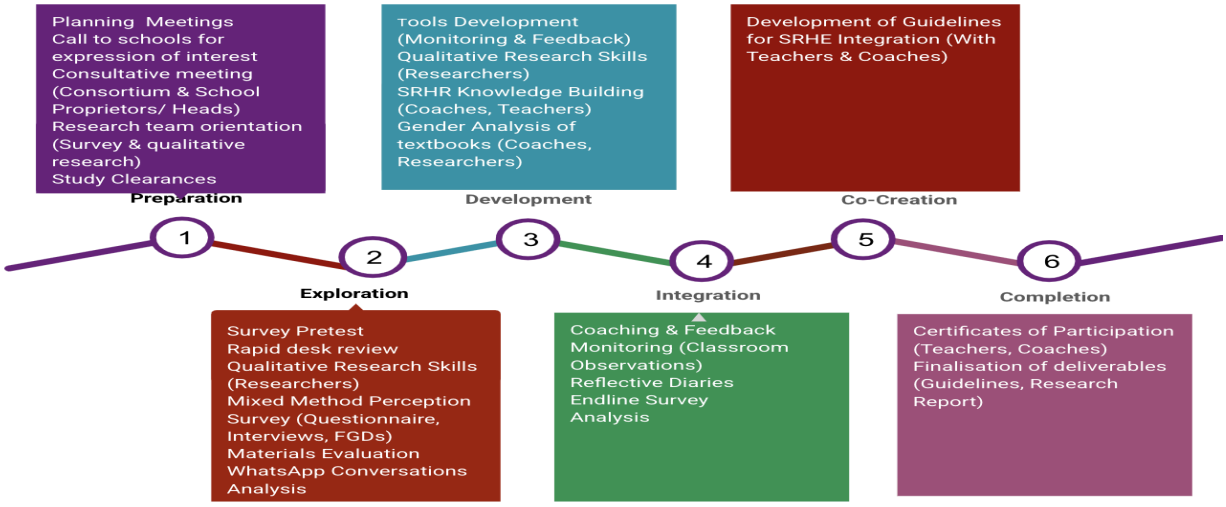

Fig. 1. The six-step study process

The study was undertaken in six iterative steps, as illustrated in figure 1. The iterative nature of this study is exemplified by the evaluation of SRHE materials, a crucial step in the research process. As outlined in Spotlight #1, the identification and subsequent evaluation of relevant materials were integral to the overall research design. The findings from these initial steps (steps one and two) directly informed the subsequent activities, demonstrating the iterative and cyclical nature of the research process.

Spotlight #1. SRHE Materials' Evaluation

Step One: In a virtual consultation with school leaders (proprietors and headteachers), a preliminary list of curricula and non-curricular materials used for Sexual and Reproductive Health Education (SRHE) instruction within their schools was identified.

Step Two: This initial list was incorporated into an online baseline survey administered to teachers from the sampled schools. Teachers were asked to confirm the usage of these materials and to identify any additional resources they utilized for SRHE instruction. Subsequently, a selection of materials from this expanded list was evaluated by the Kenyatta University-based mentee, under the guidance of senior researchers. The evaluation framework, detailed in Appendix 1, encompassed syllabi, curriculum designs, and textbooks for subjects such as Christian Religious Education (CRE), Science, Social Studies, Life Skills Education, and Home Science. The evaluation criteria included coverage of key SRHE topics, accuracy and appropriateness of content, pedagogical approaches employed, and the inclusion of relevant learning activities. The primary objective of this evaluation was to assess the current status of sexual health education within the selected schools.

Step Three, Four, Five: The insights derived from this materials evaluation significantly informed the subsequent phases of the research, including capacity building, guideline development, and coaching processes.

The enforcement of COVID-19 safety protocols (2020-2022) significantly disrupted the official school calendar, impacting our research timeline and necessitating adjustments to our fieldwork plan. The original plan for in-person data collection had to be revised to incorporate online methods, including the survey pre-test, semi-structured baseline survey, and individual interviews. Similarly, planning and consultative meetings were conducted virtually throughout the research period.

Following the easing of COVID-19 restrictions, we leveraged our existing relationships with participating schools to conduct in-person visits. We navigated the challenging academic schedules implemented to address pandemic-induced learning gaps. To accommodate these revised schedules, we conducted orientation and capacity development workshops during weekends and school holidays. While the initial design provided for four workshops, we increased this number to ten in response to the evolving needs of teachers, coaches, and junior researchers. These interactive workshops fostered lively discussions and debates, providing invaluable insights into the knowledge, attitudes, and perspectives of participants regarding sexual and reproductive health concerns.

Focus group discussions (FGDs) with teachers, school heads, and learners. During the learners' FGDs, researchers utilized drawing activities to foster trust and encourage open communication. This approach allowed children to share critical information about their environments and sexual and reproductive health concerns. Through prompts to illustrate "happy/unhappy" and "safe/unsafe" spaces within their school and community, researchers facilitated discussions around contextual issues and sexual and reproductive health.

Other in-person activities were coaching and monitoring sessions. Spotlight #2 provides further details about the coaching process.

Spotlight #2: Coaching

The coaching component of the project was built upon Dignitas' existing coaching programme in the target schools. This programme, with its three pillars of leadership, learner engagement, and classroom culture, provided a strong foundation for integrating Sexual and Reproductive Health (SRH) education. Dignitas coaches, alongside members of the research team, mentored teachers on SRH-related knowledge, attitudes, and practices.

Specific areas of focus included:

- Knowledge: Topics, reliable information sources, critical evaluation of information.
- Attitudes: Appropriate language and communication, contextual sensitivity.
- Practices: Effective teaching behaviors, diverse delivery methods, appropriate assessment strategies, engaging classroom activities, and seamless integration of SRH into the curriculum.

Coaching sessions were personalized, with in-class mentoring tailored to each teacher's unique needs and abilities. Coaches observed teachers delivering SRH-related lessons, provided constructive feedback on their knowledge, attitudes, and teaching practices, and collaboratively set goals for future sessions. This collaborative approach, involving both Dignitas coaches and research team members, ensured comprehensive and rich mentoring by leveraging diverse expertise and perspectives. The researchers observed and recorded the coaching process.

Throughout the coaching process, teachers were required to maintain reflective diaries documenting their evolving knowledge, attitudes, and practices related to Sexual and

Reproductive Health (SRH). Additionally, the research team conducted reflective sessions with teachers to further explore their learning and insights.

Research sites and study participants

The study was implemented in Huruma and Kawangware. Typical examples of Nairobi's informal settlements, these two locations grapple with severe poverty, inadequate infrastructure, and a scarcity of essential services like clean water, sanitation, and healthcare. This challenging environment significantly limits access to quality public education for children residing in these areas. As a result, many children are forced to attend schools in nearby areas or enroll in low-cost for-profit private schools, often under-resourced, which are estimated to serve approximately half of the school-aged children in these settlements. (Sande, 2019) Even when they enrol into school, many do not complete the primary cycle. Sexual and reproductive health concerns (e.g. early initiation into sex, adolescent pregnancy, sexually transmitted diseases, gender-based violence) and risk factors (e.g. poverty, cultural practices, drug and alcohol abuse, non-availability of appropriate SRH services) contribute to the relatively high dropout rates in the informal settlements (Wamahiu et al, 2022; Onguko et al, 2021).

Following our agreement on Huruma and Kawangare as the study locations, Dignitas issued a call to all their project schools in these areas, inviting them to participate in the study. Fifteen schools responded positively to this call. Subsequently, a consultative meeting with the school proprietors helped narrow down the selection to ten schools. From these ten schools, participants were chosen using purposive sampling. The final sample comprised 248 individuals, including teachers from Class 4, 5 and 6 involved in guidance and counselling/ mentorship/ overseeing co-curricular or child rights activities/teaching life skills, school managers, learners

including 12 child leaders, 4 each from classes 4, 5, 6, two coaches from Dignitas supporting the schools, and members of the research team who benefited from the capacity-building workshops. Two-thirds of the participants (65%) were female. Table 1 provides a detailed breakdown of the sample by sex, participant category and data collection method.

Table 1.

Number of study participants by sex, participant category and study method

Participant category & study method	**Female**	**Male**	**Sex Not Indicated**	**Total Participants**
Survey questionnaire (pretest - school proprietors))	6	2	2	10
On-line baseline survey (teachers)	17	16	0	33
School leader interviews (small group)	17	13	0	30
Teacher interviews	5	0	0	5
Teacher FGDs	8	7	0	15
Coach Interviews	1	1	0	2
Learner FGDs	84	24	0	108
Child leader FGDs	13	12	0	25
Workshops (average per session)	10	10	0	20
Total	161	85	2	248

Data analysis

Consistent with the qualitative, participatory research methodology guiding this study, data analysis was an ongoing and inclusive process. Data entry and analysis were conducted at two levels: during fieldwork and post-fieldwork. This approach applied to both the online survey (administered using Google Forms) and the qualitative components of the study (conducted in-person and virtually as appropriate).

Quantitative data were analyzed using descriptive statistics. Qualitative data from interviews, focus group discussions, workshops, classroom observations, and coaching sessions were analyzed thematically. MAXQDA software was employed for analyzing interview and focus group discussion transcripts, while manual coding was utilized for data from workshops, observations, and coaching sessions. This multi-method approach, including data triangulation across sources, enhanced the validity and reliability of the research findings.

Ethical considerations

This study adhered to the highest ethical standards, prioritizing child protection and safeguarding throughout the study process. Prior to commencement, we obtained the necessary research clearances from the:

- National Council of Science, Technology and Innovation (NACOSTI/P/21/11418)
- Kabianga Institutional Ethics Review Committee (IERC/2021/069)

Parental consent and children's assent were sought prior to interviewing learners in addition to authorisation by the school administration. Researchers participated in an orientation workshop emphasizing ethical research conduct, including adherence to the principles of non-maleficence (do-no-harm), informed consent, anonymity, and confidentiality.

Key findings and discussion

This section presents the research findings in three parts, aligned with the three primary research questions that guided the study. First, we examine the factors that generate the need for and shape the delivery of SRHE within Nairobi's informal settlements. Second, we delve into our discoveries regarding teachers' capacity for effective SRHE delivery, encompassing their SRH literacy levels and the availability of suitable resources to support the teaching and learning process. Lastly, we highlight notable changes that may have arisen from the research process, contributing to the enhancement of teachers' sexual and reproductive health literacy and bolstering their capacity for more effective SRHE delivery.

Factors shaping delivery of SRHE in informal settlements

Analysis of the qualitative data reveals the impact of learners' environment, upbringing, and education on their understanding of sex and its implications. Their interactions with family members, peers, the media as well as teachers shape their perceptions and attitudes towards sexuality, influencing how they navigate relationships and make decisions regarding their own sexual health and behaviour.

Sexual and reproductive health concerns of adolescents in informal settlements

The World Health Organization (WHO) recognizes that adolescents are particularly vulnerable to a range of sexual and reproductive health (SRH) concerns. These include unintended and unwanted pregnancy, unsafe abortion, sexually transmitted infections (including HIV), early marriage and childbirth, sexual violence, and harmful practices such as female genital mutilation (FGM). Additionally, adolescents can experience mental health challenges and other health problems that are exacerbated by political, economic, and sociocultural factors limiting access to appropriate SRH information and services. For children living and growing up

in the informal settlements of Nairobi, these concerns are a harsh reality, exacerbated by the COVID-19 pandemic, poverty, and persistent cultures of drug, alcohol, and violence. Spotlight #3 showcases the heightened vulnerability and the multiple risks that girls are exposed to in impoverished households, as described by a teacher from one of the sampled schools.

Spotlight #3: Teacher's perspective on girls' vulnerability

Okay for example today as we speak one of the girls in class 6 has not been in school for almost 3 weeks. She is only living with her mother. Maybe the father left; I don't know but you will find out at some point this mother is leaving in the morning or in the evening or coming in the next day. Maybe the mother is drunk working in the brothels and now whoever will take charge of these children at home is not there. That one is exposing these children. Then you will find a situation where the parents are not taking care of the children. It is not normal for a parent to leave the child unprotected but in a situation — in fact you find the father is drunk, he doesn't know where the child is, maybe he is fighting the mother day in day out making the children get scared, making the children run away from home. These children don't know where to go. Some of them only know teachers. You find like there is a time two children were living with one of our teachers because at home the hostility is very high so they only find support from teachers, and that one exposed the children to so many issues, like the sexual abuse will come in. Mostly that is what is affecting society. Drugs are everywhere. If a child is also exposed to drugs. Like one of our former girls in class 7, the mother was selling this local brew (changaa) and now when the mother is selling you see the room is one, for example, the same room where the mother is selling this brew, the same room is where the

children are, the mother is sometimes drunk, the people who are buying this brew once they are drunk they do all sort of things and that makes the children to get embarrassed losing hope.

Source: In-depth Interview, Male Teacher, Baseline Survey

Fear was an overriding theme in discussions with girl-learners; fear of being sexually harassed by people in the community including 'boda boda'[1] riders as they commuted to and from school, fear of being raped and even killed. But those were not the only 'unsafe' spaces; girls identified fields as unsafe spaces where they were 'bullied'. To quote one of the discussants of a single sex FGD, "If you're playing and other people or children come, they disturb you and they start bullying you, saying that you're like, this like that" *(Source:Girl/FGD/08)*

Others from a different school described toilets in schools as also being unsafe:

> Girl1: Because when you go there [toilet] you will find a stranger and someone might scare you and you may break your legs or anything.
>
> Girl 2: Because, if you are in the toilet then someone enters the toilet without knocking you can get scared and then you get into the hole.
>
> Girl 3: Because in the toilet, there are some holes and when you go in, any child in the other toilet can see you. (*Source: Girl/FGD/05*)

Though girls bear the brunt of various forms of sexual and gender-based violence, boys are not spared either. Study participants highlighted the vulnerability of boys who were victims of sexual violence and rape, alleging the normalisation of 'sodomy' . In an FGD, a teacher shared the story of one of the schoolboys who was being sexually abused by a man living near

[1] Motorbikes that are used as a popular means of public transportation. The 'boda boda' riders are associated with lawlessness, crime, and violence, and in the context of the topic of this study, sexual harassment and abuse.

the school. The teachers, who had been tipped off by other learners, went to the house of the man when the boy did not show up in school. In the words of the teacher

> One day when the boy did not come to school, we went to the man's house. They [the man and the boy] were found in the house but they had not started, so when the ambulance came, the boy was taken and the evidence was not there; the anus opening was there but the fluids were not there but the boy told us everything. The way the man normally does it, he uses oil first and a condom and after that he wipes him with a wet cloth and a dry one and makes sure there is no evidence. Even the man stays with him longer and feeds him and makes sure the boy goes to the toilet first before going. He is a clever man who makes sure he has dealt with all the evidence after the medical report, now you know the police just wanted to see that part, the sperms were not found so they said the evidence was not enough. (*Source: Female Teacher/Group Interview)*

However, adolescent sexual and reproductive health remains a neglected issue in the informal settlements of Nairobi. There was widespread recognition among school leaders, teachers, and learners of the risks associated with this neglect, including the negative impacts on both physical and psychosocial health, as well as educational outcomes.

Policy landscape of sexual and reproductive health education

The official position of the Kenyan government on sexual and reproductive health education (SRHE) is contradictory. It recognises the concerns described above and has intervened at the policy level. While it has endorsed numerous international and regional human rights treaties that uphold women's and girls' sexual and reproductive health rights, the implementation of comprehensive sexual and reproductive health education remains

inconsistent.[2] The policy commitment to adolescent sexual and reproductive health education is reflected in the establishment of policy frameworks and the signing of international instruments aimed at its implementation. Notably, in 2013, it pledged to expand comprehensive rights-based sexual and reproductive health education beginning at the primary school level. This commitment led to the development of a range of policy infrastructure designed to support sexual health education for young people nationwide. These policies include the Kenya Health Policy (2014-2030), the ASRH Policy (2015), the Guidelines for Provision of Adolescent and Youth-Friendly Services (2016), the Kenya School Health Policy (2018), and the National Reproductive Health Policy (2022-2032), all of which offer some guidance on the implementation of sexuality education in Kenya (CSA, 2023).

Furthermore, the government's 2013 revision of the Education Sector Policy on HIV and AIDS included provisions for age-appropriate comprehensive sexuality education and strategies to integrate it into teacher education within the context of HIV and AIDS. The 2018 Kenya School Health Policy also emphasizes equipping learners with sustainable skills and competencies, including age-appropriate sexual and reproductive health information, to facilitate a smooth transition from childhood to adolescence. The 2015 Adolescent Sexual and Reproductive Health Policy provides guidance on promoting adolescent sexual and reproductive health and rights and encourages comprehensive sexuality education. Additionally, the 2016 National Guidelines for Provision of Adolescent and Youth-Friendly Services (AYFS) urge the Ministry of Education to integrate Comprehensive Sexuality and Life Skills Education into the

[2] Article 2(5)(6) of the Constitution of Kenya 2010 specifies that all international treaties and conventions that have been ratified are part of Kenyan law. In article 21(4) it compels the government to enact and implement legislation to fulfill its international obligations.

education curriculum and build teacher capacity in providing AYFS, including comprehensive sexuality education.

There have been several iterations of SRHE in the Kenyan school curriculum, initially in the 1990s as part of the Ministry of Education's HIV and AIDs prevention strategy using Life Skills Education (LSE) as a carrier subject, and later in 2008, when LSE became a standalone subject. (Wamahiu et al., 2015) The more recent Kenyan government commitment to scaling up comprehensive rights-based sexuality education beginning in primary school in 2013 was mentioned previously. However, the implementation of comprehensive sexuality education (CSE) in Kenyan schools has faced challenges, particularly for urban poor youth, and remains a topic of ongoing debate. Stakeholders have pushed back against the term "comprehensive sexuality education," with many preferring "sexuality education" or "sexual and reproductive health education" (SRHE), the terminology used in this report.

Obstacles to sexual and reproductive health education

The operationalization of policies that guarantee sexual and reproductive health rights for children faces multifaceted and interconnected challenges. These range from the lack of political commitment (Hakansson et al., 2023) to what the CEDAW Committee describes as "cultural resistance" to providing age-appropriate sexual and reproductive health rights education. (Wamahiu and Musembi, 2023) The CEDAW Committee is a body of independent experts that monitors the progress of countries that have ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Weak political commitment is reflected in insufficient funding for SRHE, including in teacher training programmes. This creates a ripple effect, limiting the availability of teaching

materials despite their development by the Ministry of Education and Kenya Institute of Curriculum Development (KICD).

Additionally, education sector policies have predominantly promoted HIV education with a focus on abstinence, narrowing the scope of topics covered in schools. Life skills education, which could potentially incorporate a broader range of SRHE issues, was not an examinable subject in the 8-4-4 curriculum (now being phased out), further diminishing its priority for both learners and teachers. Observed one of the coaches that we interviewed, "What is being practically done in school is that the school leaders or teachers tend to give more focus on learning areas that are examined and that has really disadvantaged this area of learning called life skills."

Furthermore, reconciling rights-based approaches to information and services for adolescents with conservative perspectives that oppose certain aspects of sexuality and reproductive health education, such as improved access to contraceptives, has been a challenge. The “cultural resistance” referenced earlier includes powerful religious lobbies that have strongly opposed the teaching of sexuality education in schools, deeming the content “immoral.” Civil society organizations that have attempted to fill the gaps left by government inaction sometimes face hostility from community members who accuse them of ‘sexualizing children.’ This sentiment was echoed in the baseline survey, where some respondents highlighted the negativity of parents who, “upon hearing from their children what they are taught at school, feel that their children aren’t supposed to” learn about these topics. This reveals not only a resistance to SRHE but also a lack of understanding of what comprehensive sexuality education entails.

Status of SRHE implementation

SRHE implementation approaches, methods and channels

In the curriculum of the sampled schools, SRHE topics were integrated into subjects such as Science, Home Science, Christian Religious Education (CRE), Social Studies, and Life Skills Education (LSE), rather than being allocated a specific time. Only 9.1% of the survey respondents claimed that it was a standalone subject, though we did not find any evidence to support this assertion. Asked about the channels used for teaching this subject area, over half of the respondents (54.5%) mentioned the formal curriculum, while others identified co-curricular activities like clubs and games (36.4%) and extracurricular activities such as talks delivered at school assemblies (27.3%). A significant minority (36.4%) said they used all delivery channels, that is the formal curriculum, co-curricula and extra-curricular, to teach SRHE in their schools. Not unexpectedly, the majority of the teachers taught SRHE using teacher-centred pedagogy: question-and-answer sessions and talk-and-chalk or lecturing. Others used group discussions, assigned readings to the learners and story telling. Overall, teachers using participatory teaching methods like drama and role-play and games were in the minority. Figure 2 provides more information.

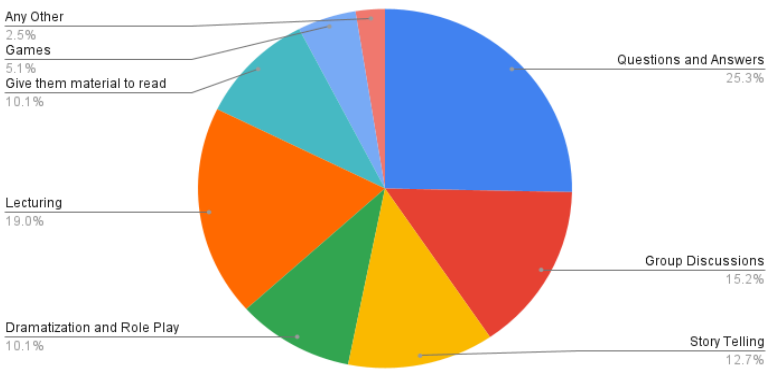

Fig. 2. Methods used to teach SRHE in schools

Teacher preparedness and SRHE literacy gaps

Due to ‘cultural resistance’, community hostility towards sexual and reproductive health education (SRHE) and its low prioritization in schools, teacher development programmes have neglected SRHE and overlooked teachers' sexual and reproductive health literacy. Figure 3 summarises the responses by those surveyed on whether their schools had any teachers trained specifically on SRHE.

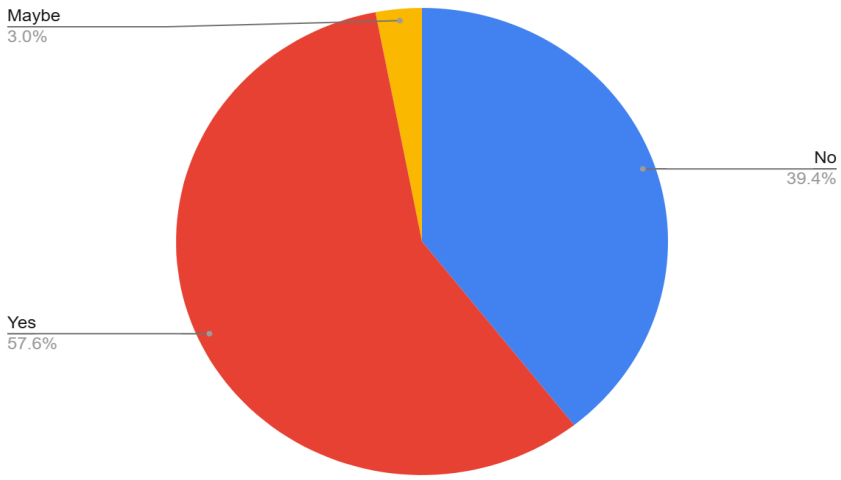

Fig 3. Percentage of sampled schools with and without trained SRHE teachers

Approximately 60% of surveyed respondents reported having a teacher trained to teach Sexual and Reproductive Health Education (SRHE) in their school. However, further investigations revealed that these teachers lacked formal training in SRHE pedagogy or integration into other subjects. As shown in figure 4, most teachers assigned to teach SRHE were Guidance and Counseling teachers, followed by Religious Education and Biology teachers. Less than 14% were Life Skills Education teachers, possibly due to the subject's low priority.

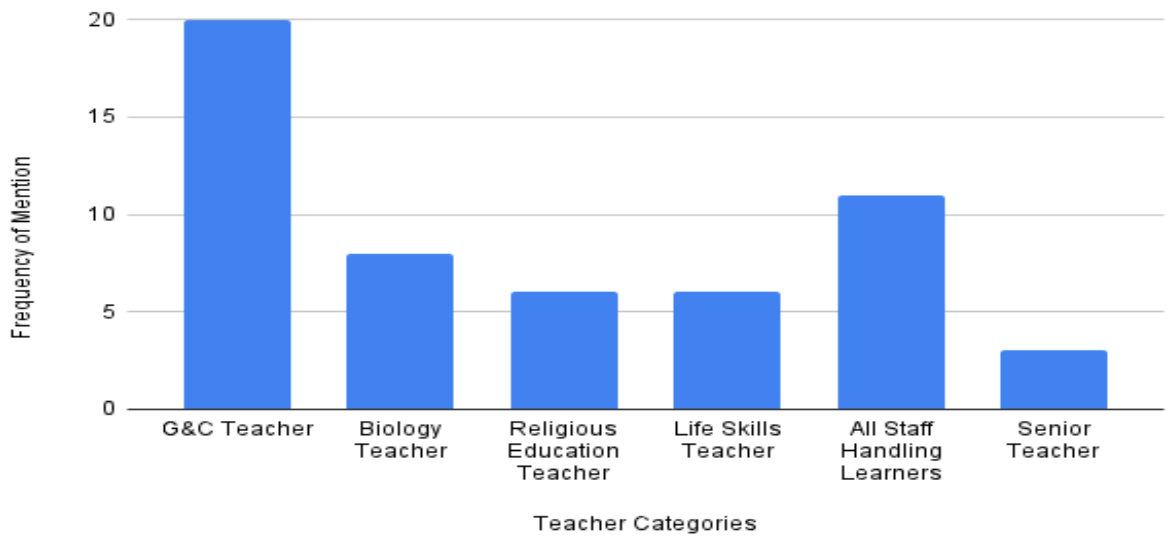

Fig. 4. Staff Responsible for SRHE-Related Topics/Subjects in Sampled Schools

Teachers in Kenyan public schools typically lack formal training in guidance and counseling, and are not experts in sexual and reproductive health. A few of the SRHE teachers stated that they had received informal training through church seminars or university training. While some teachers attended a three-day Ministry of Health training in 2021, others participated in workshops organized by the TUSOME initiative[3], churches, or Neema Hospital[4]. This lack of formal training limited their capacity to effectively counsel and guide learners on sexual and reproductive health needs.

The lack of access to relevant materials and resources further weakened teachers' ability to teach SRHE effectively. The single most mentioned source by respondents were textbooks when asked the question, 'Where do you get the material to teach SRHE from?' Other sources of information, as highlighted in figure 5, included the print media (newspapers and magazines), social media, and manuals from various civil society organisations (NGOs and FBOs). It is worth

[3] A USAID funded programme implemented between 2014 and 2022 that supported literacy development throughout Kenya and fostering a reading culture among grades 1, 2, and 3 learners including children with visual and hearing impairments.

[4] This is a hospital established by a local faith-based organisation located in Nairobi.

noting that the combined frequency of 45 for textbooks and supplementary readers is identical to that of print and social media when they are considered together. Teachers often relied on their own knowledge or searched for information online without verifying the sources.

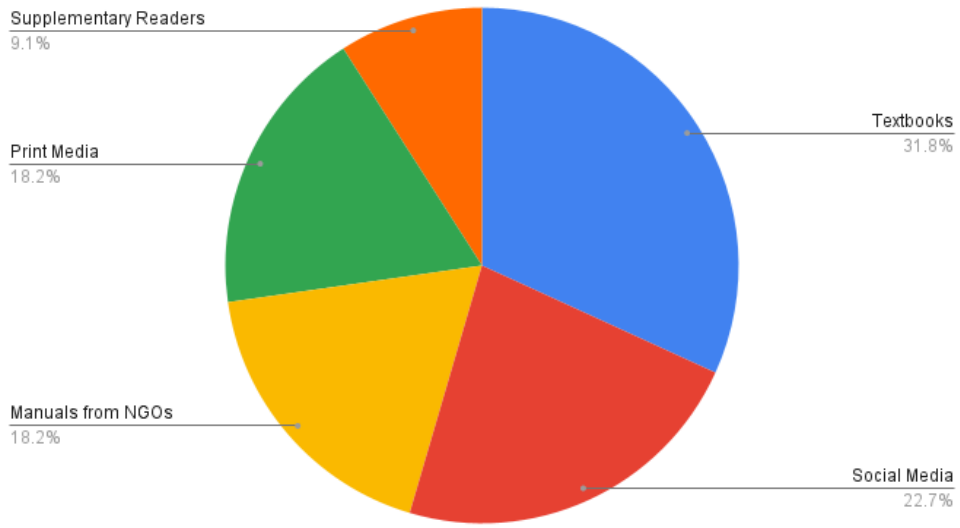

Fig. 5. Places where teachers get information for SRHE instruction

The baseline assessment revealed that teachers had a limited understanding of SRH and how to teach it. Due to religious and cultural influences, teachers often avoided direct discussion of topics related to sexuality and had a limited understanding of sexual and reproductive health. They believed that the primary focus of sexual and reproductive health should be on preventing children from falling victim to sexual predators and the risks of early sexual engagement. Classroom observations revealed that teachers avoided direct discussion of sexual topics and were hesitant to use proper terminology for sexual anatomy such as "vagina" and "penis."

The evaluation of textbooks and curriculum designs revealed alignment between the topics covered in textbooks and their corresponding curriculum or syllabus. However, many topics on the checklist were absent from both the curriculum and textbooks. While

subject-specific topics were generally factually accurate, most lacked relevance to SRH. SRH topics, when present, were not incremental, meaning students were exposed to isolated topics without a structured progression. The depth of coverage varied across subjects; for instance, social studies provided comprehensive coverage of human rights, including sexual harassment and early/forced marriage, with age-appropriate objectives promoting gender equality and addressing concerns about child abuse. Science texts and curriculum design for grades 4 and 5 lacked SRH topics, while the primary science syllabus included topics like HIV/AIDS' impact on families, food and nutrition, and puberty (limited to biological aspects), but the focus was on stating information rather than shaping attitudes or building skills. The content generally did not promote understanding human rights in relation to SRH, lacked information on gender norms and their effects, and was not disability-sensitive, although it was largely culturally relevant.

The absence of certain SRH topics in the curriculum and textbooks resulted in a significant literacy gap for both teachers and learners. Schools relied heavily on textbooks due to the limited availability of supplementary materials specifically addressing SRH issues. Although one school had access to comprehensive SRH modules from an NGO, and the Life Skills textbook covered several relevant topics, these resources were not widely available in most schools. To address this knowledge gap, teachers sought additional information from the internet and social media.

SRH literacy levels of the coaches

Coaches, despite being trained teachers themselves and some having additional qualifications in fields such as project management, lacked the specific knowledge, understanding, and skills in sexual and reproductive health literacy (SRHL) required to

effectively mentor teachers, even though they had been exposed to SRH initiatives with other organisations in previous jobs. (Coach Interviews, 2022)

Improving teacher sexual literacy and delivery of SRHE

The action research process positively impacted both the coaches and teachers' knowledge, attitudes, and practices. In the reflective sessions and in their diaries, teachers indicated a mindset shift, expressing a deeper understanding of SRH concepts, including sex, gender, and gender equality. Additionally, they were able to identify and dispel myths and biases surrounding menstruation, recognizing the importance of educating both boys and girls on the topic. For example, one teacher reported that the project had a positive impact on his comfort level when discussing SRH topics in the classroom. He stated that before the training, he and other teachers were reluctant to teach or openly discuss SRH issues. The training increased his confidence and enabled him to explore SRH topics in greater depth, whereas previously he and his colleagues had only touched on the surface and were unable to integrate these themes into other subjects.

Coaches, while confirming the changes, observed varying levels of understanding by teachers on SRHR topics, with some incorporating age-appropriate and accurate content into their lessons. They noted the ability of teachers to integrate SRH topics across various subjects using diverse activities and to critically evaluate the accuracy and appropriateness of SRH information in textbooks. Furthermore, they reported improved listening skills and a greater ability to assess and build upon learners' existing SRH knowledge.

Teachers highlighted their commitment to maintaining confidentiality when learners approached them with sensitive SRH issues. They also emphasized the importance of delivering age-appropriate SRH education at all levels and using proper SRH terminology to facilitate open

communication. Teachers learned to build upon learners' experiences, be more context-sensitive when addressing SRH matters, and avoid using learners as examples for sensitive topics, which could undermine their confidence and well-being. Overall, teachers reported increased confidence in handling SRH issues both within the school and community settings, leading to improved communication between teachers, learners, and parents and significantly improved capacity to effectively deliver SRH education, fostering a safe and supportive learning environment for learners.

A teacher discussed sharing the knowledge acquired through the research process with the church and local community to enhance understanding and dispel misinformation about SRH. He also worked with parents, guardians, and the community to support SRH education. Others reported regularly sharing insights and lessons learned with fellow teachers to enhance their SRH knowledge and teaching practices, and conducting research on SRH to broaden their knowledge base.

Conclusions

This study highlighted a critical need for improved Sexual and Reproductive Health (SRH) literacy and education. Findings emphasise the importance of early SRH education, starting from Grade 1, delivered through age-appropriate content and language. A significant challenge identified is the lack of adequate teacher training in SRH, particularly regarding sensitive topics. Teachers' insensitivity and stigmatising attitudes towards sexual health create an unwelcoming environment for students, impacting their mental well-being and hindering open discussions. This, coupled with inadequate knowledge, skills, and resources, further exacerbates the challenges faced by students. Furthermore, the primary focus on academic achievement within the school system often overshadows crucial aspects of student well-being, such as relationships, communication, and overall health.

The study observed that SRH instruction is currently scattered across different subjects, primarily Guidance and Counseling, Life Skills Education, and subjects like Religious Education and Home Science. This fragmented approach, coupled with the perception that only specific teachers (e.g., those teaching Religious Education) are qualified to address SRH, hinders comprehensive and consistent delivery. The lack of a clear framework for when, where, and how to teach SRH content leaves teachers to rely on their own knowledge and attitudes, which may be biased or inaccurate. This is further compounded by the presence of inaccurate or biased information within some SRH-related textbooks. Consequently, there is a critical need to enhance teachers' literacy levels to enable them to effectively evaluate and utilise available SRH information.

Student perspectives revealed significant challenges, including peer pressure, which influences their behaviors and decisions regarding sexual activity. Poverty also emerged as a

significant factor, particularly for boys who may be pressured into economic activities and girls who may resort to transactional sex. Moreover, early exposure to inappropriate information and behaviours within their environment raises concerns about the sources and content students access. These findings underscore the urgent need for comprehensive SRH education, a supportive school environment, and strengthened collaboration between educators and parents to address the multifaceted challenges faced by students.

The study demonstrated the effectiveness of coaching as a valuable tool for improving teacher literacy. One-on-one interactions between teachers and coaches provide a conducive learning environment. However, investments must be made in developing the capacity of coaches to support teachers' sexual and reproductive health literacy.

Furthermore, the co-creation process, which involved teachers actively participating in the development of SRH content and sharing their experiences, proved to be highly beneficial in enhancing their understanding and confidence in delivering SRH education.

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Appendix 1. Materials evaluation framework

Topics of relevance to SHR literacy	**Content**	**Approaches**	**Activities**
Relationships	Presence of topic	Age and developmental appropriateness	Diversity
Values, Rights, Culture and Sexuality	Whether the topics are incremental	Basis on human rights	
Understanding Gender	Scientific accuracy	Basis on gender equality	
Violence and Staying Safe	Comprehensiveness	Disability sensitivity	
Skills for Health and Well Being	Language appropriateness	Cultural relevance	
Human Body and Development	Appropriateness of images and illustrations		
Sexuality and Sexual Behaviour			
Sexual and Reproductive Health			

Appendix 2. Researcher Biodata

1. Dr Purity Nthiga, Principal Investigator (PI)

Dr. Purity Nthiga, lecturer of English and applied linguistics, Kenyatta University, with over 15 years' teaching and students' mentoring experience. Her research interests include literacy, communication, gender and adolescents empowerment, language education, sociolinguistics and second language acquisition. Dr. Nthiga has published research papers and book chapters on diverse language related topics. Dr. Nthiga also has wide experience in qualitative research. Dr. Nthiga strives to use her knowledge and skills to positively impact society.

2. Dr Sheila Parvyn Wamahiu, Co-PI

Sheila Parvyn Wamahiu, a Director and CEO of Nairobi-based Jaslika, has a doctorate in Education and Masters in Anthropology. She is driven by a belief in the indivisibility of humanity and the universal values of social justice, equity, equality, and inclusion. A researcher, educator and mentor, her work focuses on the intersection of education, child and youth participation, and gender justice. She has made significant contributions to policy development, programming and practice in these areas during her career of over 30 years primarily in sub-Saharan Africa. She continues to serve on several boards and expert advisory committees including the African Institute for Children Studies (AICS), Think Equal (global), and the National Advisory Board of the Action for Life Skills and Values in East Africa (ALiVE). She was a founder and founding chair of Women Educational Researchers of Kenya (WERK) among other organisations.

3. Ms Deborah Kimathi, Co-PI

Deborah Kimathi, Chief Executive Officer at Dignitas, is a strong community and social services professional.She is skilled in management of nonprofit organizations; strategic development, public speaking, proposal writing, and fundraising. A strong community and social services professional, she has a Masters in Education and International Development from University College London.