



# **Effect of Adolescents and Sexual Reproductive Health Policy on Girl Child Retention in Public Secondary Schools in Butula Sub-County, Kenya**

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## **Authors' contributions**

*This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.*

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## **ABSTRACT**

The challenge of girls' retention in educational institutions has been identified as a significant obstacle. The inability to maintain the enrollment of female students in secondary schools can be regarded as a squandering of valuable human capital and financial investments made in their primary education, as well as a loss of time invested in their initial enrollment. These young females have the potential to develop into a demographic of women lacking in literacy skills, resulting in diminished economic, social, and political contributions. Among the critical contemporary social issues affecting many countries is teenage pregnancies. The matter of ASRH is a global issue affecting both developed and underdeveloped countries. The problem has drawn attention of governments from both developed and underdeveloped nations. Researchers have also given it

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consideration and studied it to some extent in their efforts to solve the recurring puzzle of solving the sex related matters that affect adolescents. This research was guided by a general objective, the effect of adolescents and sexual reproductive health policy on girl child retention in public secondary schools in Butula sub-county, Kenya. The study also adopted specific objective as; i) To assess the effect of educational opportunities on girl child retention in public secondary schools in Butula Sub-county Kenya. The study was guided by Human Capital theory of adolescence. Research adopted the descriptive survey design. The study also targeted a sample size of 488 respondents, out of the targeted population of 1335 respondents. The criteria for selecting sample size using convenient and purposive sampling techniques was fixed upon Mugenda and Mugenda (2004) formula. Also, the data from both primary and secondary sources was utilized in the study. The instruments for gathering the data comprised questionnaires, interviews, and records from the schools. Before utilizing the instruments in this research, they were tested using test-retest methods to ascertain validity and reliability. To establish links between variables, the study used correlational analysis. Precisely, a SPSS version 25 was used when seeking to establish any link between the Adolescent Sexual Reproductive Health Policy and girl child retention in public secondary schools Butula Sub-County, Busia County. There is an expectation that this study increased towards knowledge or understanding of the effect of teenage pregnancy on class attendance in public secondary schools in Butula Sub-county. Due to the sensitivity of the research all information that was obtained it was regarded as confidential and the participants including the schools kept it anonymous. Also, no one was coerced to become part of the sample space, but consent was the criteria upon selection of respondents in the study. Therefore, this study involved the highest level of confidentiality, acknowledgment and consent when dealing with respondents and sources of data. The finding of the study was that ASRH services were significant to girl retention in schools. Moreover, it was found that information on ASRH on girls' retention was from media and school. This study recommends that school administrators assume the role of fostering a collaborative relationship between schools and the community. This partnership would facilitate the identification of opportunities for teachers, parents, and community members to collaborate in order to enhance the educational outcomes of students.

**Keywords:** *Sexual reproductive health policy, girls' retention; STI infections; reproductive health education; sexuality.*

## 1. INTRODUCTION

It is reported that the global challenges facing adolescents and young adults (AYAs) are related to Adolescent Sexual and Reproductive Health (ASRH). These problems included Teenage pregnancies and parenthood, limited access to contraceptives, high infection rates of sexually transmitted infections (STIs) like HIV/AIDS, and unsafe abortions [1]. The same has been reported by UNAIDS [2], who contends that significant sex and reproductive health problems are facing AYAs, which comprise of AYA marriages, female genital mutilations (FGM), unplanned pregnancies, forced sex, gender inequalities, abortions, STIs, among others. UNESCO confirms that difficulty in thinking and concentration is a consequent key result of the effects that AYAs face, which directly impacts their cognitive capacities and performances [3].

World Health Organization [4] reports that the number of AYAs between the age brackets of 15–19 years that give birth annually is at sixteen

million, accounting for 11% of the global annual births, of which low and medium-income Countries (LMICs) contributes to 95% of these births. More statistics from the same report show that the percent of teenage pregnancies as expressed out of the total pregnancies is relative from region to region with 2%, in China, Early pregnancy is a significant problem among AYAs mothers of about 16 years in LMICs, where, almost 10% of 16 years AYAs girls become mothers, especially in South Central and Southeast Asia and Sub-Saharan Africa, which has the highest percentages.

According to UNAIDS [2], 75% of new HIV infections is among AYAs in the age bracket of 15–24 years within eastern and southern Africa. Again, the same report indicates that AIDS-related infections are the major killer of AYAs girl child in third world countries in Africa. According to the United Nations Population Fund [5], poor communication in addition to poor medical healthcare facilities are key factors influencing AYAs.

Furthermore, because schools impact communities and host the majority of adolescents, they play an essential role in propagating issues of ASRH more than any other institution. It is so because schools have teachers who possess vast knowledge of all matters that affect the AYAs, have resources pooled together by government and parents, and have enough facilities and platforms for educating adolescents [6-9]. In addition to teaching the adolescents, the teachers in the schools, serve as role models to adolescents and play a vital role in community empowerment. Additionally, the World Health Organization [1] avers that schools are the only place where students have a guarantee of accessing accurate information delivered most appropriately. Consensus view by Education for all as showed in the World Evaluating Report of 2012 supports the notion that schools are the main institutions in society for formal learning and acquisition of key life skills.

By offering reproductive health education to AYAs, especially girl child at the early stages of life, schools lead to the formation of the desired healthy sexual practices and attitudes. Early and healthy sexual practices and attitudes are important and helpful in raising a prosperous society, unlike trying to change the already established unhealthy practices within societies [10,11-15]. Therefore, schools can and should provide healthy sexual reproductive education and come up with a standard for the helpful norms and practices about SRH. Therefore, girl child retention is an essential factor for ASRH policy to succeed (Ibid). As such, there is a need to investigate adolescents' and sexual reproductive health policy on girl child retention in public secondary schools.

Secondary education is another stage of the basic education that hosts 80% of the AYAs in the age bracket of 10-15 years and maybe compulsory in most countries that abide by UNESCO guidelines [16]. As such, the ability to host a large population of AYAs makes schools the most appropriate institution that can impact the AYAs girl child's reproductive health when properly put to use. Healthy sexual practices that come with the right reproductive health among AYAs girl children include frequent medical checkups, condom use, an increased spectrum of understanding about STI, and low HIV/AIDS infections. In abstract, School-based HIV and SRH education is crucial for equipping AYAs girl child with the skills and knowledge for the

appropriate sexual practices that make them less vulnerable to STIs and, in particular, HIV/AIDS [5].

According to the Ministry of Health [17], Kenya, on the other hand, has made great advancements with policies and legal frameworks that specifically protect AYAs through promoting their rights to appropriate SRH and the rights and freedom of the AYAs, especially the girl child. Regardless of the plethora of legal frameworks, Kenya still lags behind in terms of Adolescent Sexual and Reproductive Health and Rights (ASRH) indicators, where the majority are extremely low to the negative side (KNBS and ICF Macro, 2014; KNBS & ICF Macro, 2010). Although the policies are meant to deal with the issues of ASRH, reports indicate that ASRH is still a challenge in Kenya, including Busia County, where Butula Sub County is located [18]. It is more compelling that the legalities and the legitimacies are not sufficient or effective enough to guard and protect the girl child education and adolescents at large. Therefore, prompting for the most lucrative and sufficient alternative to handle the problem. But nothing can be valuable or practical without the intervention of the scholarly realm. It is therefore imperative to study the effect of adolescents and sexual reproductive health policy on girl child retention in government-sponsored secondary schools in Butula sub-county, Kenya.

Factsheet 2016 shows the rate of adolescent SRH in the county of Busia. The data are drawn from the 2014 Demographic and Health Survey, 2012 Kenya AIDS Indicator Survey, and the 2014 Basic Education Statistical Booklet. The fact sheet highlights the following Adolescent SRH Indicators; Half of Busia County women (20-49 years old) and men (20-54 years old) first had sex by age 17. Therefore, women in Busia County first have sex one year earlier than the national trend. Whereas the trend among the men is similar to that at the national level; girl child age-specific fertility rate in Busia County indicates 128 births per 1000 girls aged 15-19 (adolescent birth rates; 1.6% of youth aged 15-24 in Western province, where Busia rate but higher than in some regions where the rates are 1% or lower (Central and Eastern provinces) [17]. The ASRH results, as highlighted, eventually affect girl child retention in both primary and secondary schools.

**Problem Statement:** The matter of ASRH is a global issue affecting both developed and

underdeveloped countries. The problem has drawn attention of governments from both developed and underdeveloped nations. Researchers have also given it consideration and perused it to some extent in their efforts to solve the recurring puzzle of solving the sex related matters that affect adolescents. The United States of America, which is miles ahead of the other developed nations, is still experiencing unhealthy sex practices among the AYAs. The effects are straining the nation both economically and socially. In Africa, countries in sub-Saharan Africa are experiencing more adverse impacts because of the prevailing level of implementation of the ASRH coupled up with poverty. Uganda is facing worse conditions, and so is Kenya.

Regardless of limited indicators from the sub-Saharan Africa about the extent of unhealthy sex practices and the prevailing impacts, the few pieces of research reveal massive deficiencies and distressing data. As in other counties in Kenya, Busia County presents a worrying trend in matters of ASRH that has led to drop out of school among the girl child. According to UNICEF (2017), 18% of women between 15-19 years had in 2008 given birth to at least one child in Busia County, where Butula Sub-County is located. According to the African Institute for Development Policy [18], there is variation in dropout rates among girls and boys aged 13-18 at 45% and 37% respectively. Although both boy child and girl child are affected this statistics was skewed towards the girl child and poses an adverse impact on the mother and the child's health, and to a large extent, it impounds individual and social consequences of the girl child. According to Omoroa et al. [19], these include the curtailment of the girls' education and loss of societal human resources [19] as it affects girl child retention in schools.

Although many empirical studies on ASRH have been conducted in Kenya [20,21,22,23,24,25] among others, it has been noted that there are contextual, methodology, and conceptual gaps since none of all prior studies conducted have addressed the effect of adolescents and sexual reproductive health policy on girl child retention in public secondary schools in Butula sub-county. This proposed research intends to fill these gaps by specifically investigating the effect of ASRH information, ASRH services, educational opportunity, and community involvement on girl child retention in public secondary schools in Butula sub-county, Kenya.

**Specific Objective:** This specific Objective that guided the study include;

- i) To establish the effect of ASRH services on girl child retention in public secondary schools in Butula sub-county, Kenya

## 2. LITERATURE REVIEW

### 2.1 Effect Asrh Services on Girl Child Retention in Public Secondary Schools

Barroy, Cortez, Nora, and Wang [26], in the research seeking to establish all the adolescent sexual and reproductive needs, sought to inform policies and intervention design on how best to meet the adolescent sexual and reproductive needs through increased access to adolescent SRH services in Niger. It was established from research that the average age for first marriage is 15.7 years while sexual debut being 15.9 years. Within urban settings, adolescent girls and boys started spending time together at age 12, whereas they began at the age of 10 years in the rural. The close association of boys and girls results in sexual intercourse for material benefit or financial gain. At the age of 18, more than 70 percent of girls have given birth. A major section of the adolescents does not use protection because of the societal, cultural practices, and belief systems. Most youths were aged 15-19 years who fail to use protection cite insufficient financial resources, limited privacy, and confidentiality as the main reasons.

On the other hand, Ntulume [24] researched the association of Adolescent Sexual and Reproductive Health (ASRH) services with the adolescent in secondary schools of Ssekanyonyi sub-county, Mityana district, in Uganda. Its main purpose was to establish the use of ASRH services among adolescents in secondary schools in the Mityana district, highlighting all the barriers to its implementation and utilization. From the findings, the age for the first sexual debut was 14years. Also, by the same age, more than 42% of adolescents had had sex with the male taking the highest proportion by 69% (OR 1.69, p-value =0.013) where more male at 72% ( $r = 1.72$ , p-value =0.0002) being more likely to be sexually active than females. 11.3% of the respondents agree to have impregnated or become pregnant. Despite the utilization of ASRH services in schools, including counseling services at 36.5% and abstinence at 41.2%, the prevalence of Sexually Transmitted Infections stands at 22% among adolescents. The seniors

within secondary schools have low mastery of the incentives, knowledge, equipment, and ASRH service provision training. A cross-sectional descriptive analysis with an in-depth analysis. To ensure that both qualitative and quantitative methods were utilized within the study on a sample of adolescents between the ages of 14-19 years. After feeding quantitative data in Epidata 3, it was analyzed through the STATA 12, while qualitative data was analyzed through interpretation and content analysis. The study concluded that adolescents in secondary schools have access to ASRH services in their schools. However, it is ineffective because of insufficient tools for ASRH service provision, which leads to unwarranted reproductive health practices like early sexual intercourse among teenagers, rampant abortions, and high STI infections.

A study by Kamai [20] targeted the factors affecting health care service utilization by married AYAs and how prevalent they are in Bangladesh. The study relied fully on the health survey data of 2004 and the demographic parameters during the same year. In conclusion, the study established that the level of utilization of the health facilities by married AYAs was extremely low. Of all married AYAs, only 52.5% accessed the antenatal care service. Even so, a small percentage of 14.4 utilized the skills of skilled childbirth professionals during their parturition. Worst still, the smallest percentage of 10.7 of babies by AYAs are delivered in medically equipped facilities. There was a statistical significance between the fixed-effects binary logit models and the socio-demographic factors to the service utilization by AYAs (at  $p < 0.001$ ). The main determinant of maternity care access by AYAs comprises the order of birth, residential place, and region of origin. The study's recommendation was an extensive integration of the programs for safe motherhood among AYAs in Bangladesh.

Banke-Thomas, Aduragbemi, and Ameh [27] conducted a study to establish how the adolescents mothers from low and middle income countries are affected and by what factors so that their accessibility to maternal health factors is impacted: a systematic review. The literature review was consisting of all articles concerning factors limiting young adolescents from utilizing knowledge about adolescent mothers published until December 2015. It is basically about the utilization of MHS in the assessment of LMICs young adolescent

mothers. The data extracted in the study reported both factors that affect AYAs alongside the geographical and demographic parameters. It was summarized under the study's developed themes, which comprise the factors considered statistically significant by the researcher to affect AYAs, the effect of utilization of MHS, and any other findings that can affect MHS. The study revealed limited pursuit of the study area by the researcher, and only shallow pieces of data exist on the same. However, despite the low research on the topic, the study still was confined to the research conducted within five years from the date of study as a secondary data source. As a result of ten studies about AYAs in marriage were sampled. Among the studies chosen, the key findings of factors impacting AYAs included wealth aspects, level of exposure to mainstream and social media, and place of residence as either rural, urban, or peri-urban and education level AYAs. Of all the factors, the quality and quantity of education accessed significantly affects the AYAs utilization of the MHS to the largest extend. It was also established that antenatal care to the greatest extend helps promote the use of skilled birth attendance and utilization of postnatal care services among AYAs. However, other context-specific factors need to be looked into, which is the pursuance of this research.

Taking neutral grounds, the provision of ASRH is essential in combating the factors affecting AYAs especially the girl child. Going by the statistics, the girl child faces early pregnancies and needs continuous testing and counseling for STIs especially HIV/AIDS. The access to ASRH will promote management and containment of STIs and will reduce complications resulting from their pregnancies so that they can continue pursuing their goals for education despite their actions. Therefore every policy aiming at improving the health of the girl child must address effective and efficient use of ASRH by adolescents.

## 2.2 Theoretical Framework

This study is conducted in line with Human capital theory. The theory highly advocates for formal education as the basis upon which great milestones in a population's productivity can be achieved. The improved productivity of human capital is a result of improved cognitive capabilities, which is a consequence of proper education. With improved cognitive capabilities, economic productivity is expected to improve since it relies on the population's intellectual

strength, which awakens and propounds the innate capabilities. Therefore, it is factual from the theory that formal education is more of an investment in individuals. There is more emphasis on training as the only way to keep a population in momentum with the new global economic growths. While discussing the theory, Babalola (2003), asserts that the impact of education on economic growth is felt through the expansion of the existing labor forces productivity both qualitatively and quantitatively. A high school dropout, therefore, affects the development of human capital.

In the critique of the theory, Almendarez (2010) asserts that the human capital theory and educational systems work together to develop individuals and nations, especially developing nations. But the level of implication of the theory varies based on the quality of the education system, which depends on the type of policies and legal frameworks in place and the expenditure on the same. The human capital theory emphasizes the need for an increased allocation of resources to nations' education systems to make it more expansive. The expansive education system should be directed towards equal access to quality and quantity education by both the boys and girls. The human capital theory is relevant to the proposed study as students drop out of school negatively affect adolescents and sexual reproductive health policy on girl child retention in public secondary schools in Butula sub-county, Kenya. Teenage pregnancies have negative implications on the human labor forces because it increases dropout rates from schools and low academic attainments upon completion of a course. Also, AYAs girl children who drop out tend to show deterioration in performance upon re-admission. Therefore, this theory lends enough to.

### 3. METHODOLOGY

The Methodology and modalities in data collection are outlined in this chapter. It deals with the design, location of the study, target population, ways of getting the samples, sample size, tools for collecting data, validity and reliability of data collected, data source, methods of collecting data, and data analysis methods.

#### 3.1 Research Design

The study employed a descriptive survey design for the research. The design utilized many techniques for identifying methodologies in the

process of data collection. The aforementioned approach held significance due to its incorporation of both qualitative and quantitative data. According to a previous study conducted by Bowling (2019), survey research facilitates the systematic gathering of comprehensive and verifiable data. Survey research serves the purpose of describing and justifying existing phenomena, as well as providing insight into current situations and practices. This study focused on examining the impact of sexual reproductive health policies on the retention of female students in public secondary schools in Butula sub-county, Kenya. The methodology of the study facilitated a comprehensive examination of the factors, allowing for a deeper understanding of the implementation of reproductive health education and sexuality in secondary schools in Kenya.

#### 3.2 Location of the Study

The study was conducted in the Butula sub-county, Busia County, Kenya. The area for the study is cosmopolitan and houses about 140,334 people (2019 Population and Housing Census). It has a population density of about 568 persons per square kilometer. Majority of people are farmers, traders and livestock farmers. The main cash crop is sugarcane. The location is ideal because it gives the most appropriate settings to study the ASRH as impacting girls across multi-correctional cultures. It also has the required public school at all the categories hence most suitable for studying the perimeters in the study.

#### 3.3 Target Population

Since the work was carried among 26 schools with girl students, the target population totalling 1,355 individuals is distributed as follows; one officer, 26 Principals, 26 Deputy Principals, 26 G/C teachers, 26 class teachers and 1,224 girl students, and 26 school nurses.

**Table 1. Target population**

| Position          | Target Population |
|-------------------|-------------------|
| Girl Students     | 1224              |
| Principals        | 26                |
| Deputy principals | 26                |
| G&C teachers      | 26                |
| Class teachers    | 26                |
| School nurses     | 26                |
| Education officer | 1                 |
| <b>Total</b>      | <b>1355</b>       |

### 3.4 Sampling Procedures

The research employed cluster sampling methodology to group schools within Butula sub-county into distinct geographical clusters. The technique of stratified sampling was employed in order to discern several sub-groups within the target population. These sub-groups consisted of students, principals, deputy principals, G&C teachers, class teachers, school nurses, and Education officers. Purposive sampling is a technique employed to deliberately pick individuals who possess the necessary knowledge [28]. Consequently, the researchers employed purposive sampling as a method to select the female students. The method employed for sample selection was simple random sampling, which ensured that samples were chosen without any bias from the accessible population. This approach was justified based on the principle that every member of the population had an equal and independent opportunity of being selected.

### 3.5 Sample Size Determination

A sample is a smaller group obtained from the accessible population. This research drew a sample size using Yamane's formula [29].

$$n = \frac{N}{1 + N(e^2)}$$

n = the desired sample size

N = the total population

e = the level of statistical significance

Therefore the sample size for girl students is

$$n = \frac{1224}{1 + 1224(0.05^2)} = 301.4 \approx 301$$

$$Non - response = \frac{5}{100} \times 1224 = 61.2 \approx 61$$

$$Total sample size = 301 + 61 = 362$$

Therefore the sample size for principals, deputy principals, G&C teachers, nurses and class teachers is

$$n = \frac{26}{1 + 26(0.05^2)} = 24.4 \approx 24$$

$$Non - response = \frac{5}{100} \times 26 = 1$$

$$Total sample size = 24 + 1 = 25$$

**Table 2. Sample size**

| Position          | Sample size |
|-------------------|-------------|
| Girl Students     | 362         |
| Principals        | 25          |
| Deputy principals | 25          |
| G&C teachers      | 25          |
| Class teachers    | 25          |
| School nurses     | 25          |
| Education officer | 1           |
| <b>Total</b>      | <b>488</b>  |

### 3.6 Research Instruments

The information was gathered using questionnaires which were used together with interview guides which were used to complement the questionnaires. The questionnaires were for the deputy principals, class teachers and guidance and counseling teachers, students and school nurses. The interview guides were for the education officer and principals so as to supplement data from the questionnaires.

### 3.7 Questionnaires for Deputy Principals, Guidance and Counselling Teachers, Class Teachers, School Nurses and Students

The primary data in this research was gathered using a semi-structured questionnaire. It is appropriate to gather information about phenomena from large sample spaces with many groups of people with varying characteristics [30]. The questionnaire used here contains questions framed about research parameters. It was organized so that the first schedule seeks information about personal data comprising age, gender, level of education, and designation. The other schedules have questions on the study variables as per the structure of the study. All these questionnaires were tested before actual use by drop and pick later send to the various schools [31].

Responses for this research were rated relying on a Likert scale that ranged from 1 (no extent) to 5 (huge extent) or 1 (strongly disagree) to 5 (strongly agree). The questionnaire method is considered in this research because of its low cost, minimizes bias error, increases anonymity, and considers responses after sufficient consultations and data sourced from respondents over a wide geographical location. Additionally, the instrument has unstructured

questions for personal opinions and extensive explanations and suggestions. Questionnaires served best for the research since it increased respondents' accessibility over a limited time. A process that enhanced the collection of individual ideas from the respondents due to the openness of some questions. The questionnaire were administered to the guiding and counselling teachers, class teachers, students, deputy principals, and the school nurses. The student questionnaire comprised of many items and scales designed to investigate students' awareness, attitudes, and perspectives regarding retention. The survey also aimed to ascertain if respondents were acquainted with individuals who had discontinued their education as a result of pregnancy, or individuals who have subsequently returned to the school system following childbirth.

### **3.8 Key Informant Interview Guides for the Sub County Education Officers and Principals**

Interview guides were helpful during interviewing key respondents like the Sub-County Director of Education. The interview guide in this study was utilized when gathering information from iconic individuals in the sample population while verifying the reliability of the questionnaire's information. The interview was administered to Education Officers and principals. The interview is considered vital to the specific individuals in the sample space, as mentioned earlier, because it helped gain more in-depth information about study parameters, unlike the questionnaires. A set of questions to be interviewed were provided.

### **3.9 Validity of Instruments**

Validity helps examine the level of accuracy in tools, measuring precisely what it is meant to measure. Contemporary views of validity seem to narrow down to measuring the scores and interpretation derived from the instruments. Thus validity depends on the extent to which meaningful and appropriate inferences or decisions are made based on scores derived from the instrument used in research. For the validity of the data obtained from various instruments, the content went through the research experts and research supervisor to validate. Experts, who were supervisors, checked the instruments' content coverage based on the study parameters defined in the research. My peers had a chance to peruse and

comment on the content, a process which enhanced internal consistency.

### **3.9 Reliability of Instruments**

Reliability is the determination of the extent by which the tool of measure used in the study results in the consistent outcomes after several trials of instruments on different areas [32]. The test-retest method was vital when measuring reliability in this research. The instrument used ten girls' secondary schools from Teso South Sub County, Busia County. The Pearson's Product Moment Correlation Coefficient formula is given as; a value of above 0.8 indicated reliable. The principals', teachers' and students' questionnaires yielded reliability values of 0.8936(0.9), 0.9137(0.9) and 0.8871(0.9) respectively. The reliability values obtained were significant hence, the instruments were considered reliable.

### **3.10 Data Collection Procedures**

Once the research proposal had been prepared and granted approval, the researcher proceeded to acquire a research permit from the National Commission for Science, Technology and Innovation (NACOSTI). Subsequently, the researcher proceeded to the office of the County Director of Education (CDE) in Butula Sub County, where they were provided with a formal letter granting authorization for the research to be conducted inside the aforementioned Sub County. Additionally, the letter had the purpose of introducing the researcher to the respective principals involved in the study. The researcher thereafter conducted visits to individual schools a fortnight prior to the commencement of data collecting. The objective of this activity is to provide participants with a familiarization session prior to the administration of the instruments. It serves as an opportunity to schedule appointments with the required individuals.

### **3.11 Data Analysis Procedure**

The research produced data of both qualitative and quantitative kind. The quantitative data underwent coding and was subsequently entered into a computer system utilizing the Statistical Package for the Social Sciences (SPSS). The data was presented using tables, bar graphs, and pie charts. The initial coding process was the discovery and further refinement of categories and themes within the qualitative data. Therefore, the themes derived from the research objectives were classified and elucidated in order



to examine the qualitative data collected from each questionnaire.

The data for this study was analyzed utilizing both descriptive statistics and inferential statistics.

#### 4. DISCUSSION

This chapter presents data analysis results from questionnaires, interviews and record inspection with a view to answer research questions

##### To Establish the Effect of ASRH Services on Girl Child Retention in Public Secondary Schools in Butula Sub-county, Kenya

**Students questionnaire:** The researcher sought to find out from students whether they receive Adolescent Sexual Reproductive health services at the school. The results are shown in Table 3.

From Table 3, the results shows that 313(100.0%) received adolescent Sexual Reproductive health services at the school

The researcher also sought to find out the kind of ASRH services offered in school. The results are shown in Table 4.

In Table 4, the result shows that 296(94.6%) is on abstinence, 232(74.1%) is on STI/HIV prevention and 295(94.2%) is on condom use. The results also reveals that 251(80.2%) is on

counselling, 176(56.2%) is on menstruation education and 234(74.8%) is on sanitary pads. The research further reveals that 295(94.2%) is not on condom use, 294(87.5%) is not on pregnancy testing and 294(93.9%) is no on family planning/contraceptives.

The researcher also sought to find out whether ASRH services affect girl child retention in public secondary school. The results are shown in Table 5.

From Table 5, the results shows that 119(38.0%) of the girl child are affected.

**School nurse questionnaire:** The researcher sought to find out the effects of ASRH services on girl child retention.

In Table 6, the results shows that 19(95.0%) is on abstinence, 13(65.0%) is on STI/HIV prevention and 11(55.0%) is on condom use. The results also reveals that 14(70.0%) is on counselling, 13(65.0%) is on pregnancy and 14(70.0%) is on relationship. The research also reveals that 13(65.0%) is not on contraceptive, 18(90.0%) is not on menstruation and 12(60.0%) is on sanitary.

**Class teachers questionnaire:** The researcher sought to find out the awareness of any student who dropped out of school in the last 1-4 years of your being in the school.

**Table 3. ASRH services in school**

|       |     | Frequency | Percent |
|-------|-----|-----------|---------|
| Valid | YES | 313       | 100.0   |

**Table 4. ASRH services offered in school**

|                               |     | Frequency | Percent |
|-------------------------------|-----|-----------|---------|
| Abstinence                    | No  | 17        | 5.4     |
|                               | Yes | 296       | 94.6    |
| STI/HIV prevention            | No  | 81        | 25.9    |
|                               | Yes | 232       | 74.1    |
| Condom use                    | No  | 295       | 94.2    |
|                               | Yes | 18        | 5.8     |
| Pregnancy testing             | No  | 274       | 87.5    |
|                               | Yes | 39        | 12.5    |
| Relationship counselling      | No  | 62        | 19.8    |
|                               | Yes | 251       | 80.2    |
| Family planning/contraceptive | No  | 294       | 93.9    |
|                               | Yes | 19        | 6.1     |
| Menstruation education        | No  | 137       | 43.8    |
|                               | Yes | 176       | 56.2    |
| Sanitary pads                 | No  | 79        | 25.2    |
|                               | Yes | 234       | 74.8    |

**Table 5. Extent of ASRH services effect on girl child retention**

|       |                     | Frequency | Percent |
|-------|---------------------|-----------|---------|
| Valid | No extent           | 37        | 11.8    |
|       | Some extent         | 119       | 38.0    |
|       | moderate extent     | 86        | 27.5    |
|       | considerable extent | 46        | 14.7    |
|       | great extent        | 25        | 8.0     |

**Table 6. Effects of ASRH services on girl child retention**

|                |     | Frequency | Percent |
|----------------|-----|-----------|---------|
| Abstinence     | YES | 19        | 95.0    |
|                | NO  | 1         | 5.0     |
| STI/HIV        | YES | 13        | 65.0    |
|                | NO  | 7         | 35.0    |
| Condom         | YES | 11        | 55.0    |
|                | NO  | 9         | 45.0    |
| Counseling     | YES | 14        | 70.0    |
|                | NO  | 6         | 30.0    |
| Pregnancy      | YES | 13        | 65.0    |
|                | NO  | 7         | 35.0    |
| Relationship   | YES | 14        | 70.0    |
|                | NO  | 6         | 30.0    |
| Contraceptives | YES | 13        | 65.0    |
|                | NO  | 7         | 35.0    |
| Menstruation   | YES | 18        | 90.0    |
|                | NO  | 2         | 10.0    |
| Sanitary       | YES | 12        | 60.0    |
|                | NO  | 8         | 40.0    |

**Table 7. Dropout**

|       |     | Frequency | Percent |
|-------|-----|-----------|---------|
| Valid | YES | 18        | 90.0    |
|       | NO  | 2         | 10.0    |

In Table 7, the results shows that 18(90.0%) were aware of students drop out.

The researcher sought to find out what extent ASRH services affect girl child retention at the school.

From Table 8, the results shows that 10(50.0%) of the girl child are affected to some extent.

**Guidance and counselling questionnaire:** The researcher sought to find out the ASRH services provided at the school.

In Table 9, the results shows that 20(100.0%) is on abstinence, 18(90.0%) is on STI/HIV prevention, 20(100.0%) is on counselling, 12(60.0%) is on pregnancy testing, 20(100.0%)

is on relationship, 18(90.0%) is on menstruation and 18(90.0%) is on satinary. The result further revealed that 16(80.0%) is not on condom use and 17(85.0%) is not on contraceptives.

The researcher sought to find out how many G/C services do you offer on reproductive health in a term.

From Table 10, the results shows that 10(50.0%) of the girls are guided weekly.

The researcher sought to find out programs in place to debut and promote sexual abstinence among the adolescent's girls.

From Table 11, the results shows that 20(100.0%) of the programs were in place.

**Table 8. To what extent that ASRH affect girl child retention**

|       |                     | Frequency | Percent |
|-------|---------------------|-----------|---------|
| Valid | No extent           | 3         | 15.0    |
|       | Some extent         | 10        | 50.0    |
|       | Moderate extent     | 2         | 10.0    |
|       | Considerable extent | 1         | 5.0     |
|       | Great extent        | 4         | 20.0    |
|       | Total               | 20        | 100.0   |

**Table 9. ASRH services**

|                             |     | Frequency | Percent |
|-----------------------------|-----|-----------|---------|
| Abstinence                  | YES | 20        | 100.0   |
| STI/HIV                     | NO  | 2         | 10.0    |
| Condom use                  | YES | 18        | 90.0    |
|                             | NO  | 16        | 80.0    |
| Counseling                  | YES | 4         | 20.0    |
|                             | NO  | 20        | 100.0   |
| Pregnancy testing           | YES | 8         | 40.0    |
|                             | NO  | 12        | 60.0    |
| Relationship Contraceptives | YES | 20        | 100.0   |
|                             | NO  | 17        | 85.0    |
| Menstruation                | YES | 3         | 15.0    |
|                             | NO  | 2         | 10.0    |
| Sanitary pads               | YES | 18        | 90.0    |
|                             | NO  | 2         | 10.0    |
|                             | YES | 18        | 90.0    |

**Table 10. How frequent do you conduct G & C in a term**

|       |                | Frequency | Percent |
|-------|----------------|-----------|---------|
| Valid | Weekly         | 10        | 50.0    |
|       | Monthly        | 3         | 15.0    |
|       | once in a term | 7         | 35.0    |
|       | Total          | 20        | 100.0   |

**Table 11. program in place**

|       |     | Frequency | Percent |
|-------|-----|-----------|---------|
| Valid | YES | 20        | 100.0   |

## 5. CONCLUSION

**To establish the effect of ASRH services on girl child retention in public secondary schools in Butula sub-county, Kenya**

The study also observed that the ASRH services that were taught girls while in public secondary schools included; an abstinence, education on STI/HIV prevention, proper use of condom ,regular pregnancy tests, an education on family planning and menstruation. The above services created an effect on girl child retention in public secondary schools in Butula sub-county Kenya.

## 6. STUDY RECOMMENDATION

**To establish the effect of ASRH services on girl child retention in public secondary schools in Butula sub-county, Kenya**

It is imperative to educate parents and guardians of school-going children about the necessary measures that need to be taken to ensure the retention of learners in educational institutions. This initiative is crucial in adequately equipping young individuals to assume significant responsibilities in the future. The achievement of high retention and transition rates in secondary education is contingent upon the implementation

of sustainable poverty eradication strategies, as it is recognized that a child's ability to learn is hindered by the problems posed by poverty, including inadequate access to nutrition.

## CONSENT

As per international standards or university standards, respondents' written consent has been collected and preserved by the author(s).

## COMPETING INTERESTS

Authors have declared that no competing interests exist.

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