

UNDERSTANDING TEENAGE PREGNANCY IN KENYA: THE MAGNITUDE AND POLICY INTERVENTIONS

Accelerating Access to Adolescent Sexual and Reproductive Health and Rights in
Eastern and Southern Africa through Advocacy



Approximately

16 MILLION

**GIRLS AGED BETWEEN 15 TO
19 YEARS**

GIVE BIRTH EVERY YEAR
GLOBALLY, (WHO,2020).



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We are optimistic that this review will inform current and future advocacy and programmatic interventions aimed at addressing sexual and reproductive health and rights for adolescents and young people.

EXECUTIVE SUMMARY

Approximately 1.2 billion adolescents aged 10-19 years today make up 16 percent of the world's population. Sub-Saharan Africa is the region where adolescents make up the greatest proportion of the population, with fully 23 percent of the region's population aged 10-19.¹ Adolescence is a key stage of the life course that affects health, opportunities, and development for the rest of life. It is a time of physical, mental, social, and emotional change accompanied by an increasing definition of sexual identity and social status. These adolescents are living in a world undergoing demographic transition, a growing reliance on new communication technologies. Managing these changes to achieve optimal health and personal development is challenging.

Globally teenage pregnancies and motherhood remain a major cause for concern for the health and well-being of adolescent girls and young women. About 16 million girls aged between 15 to 19 years and about one million girls younger than 15 years give birth every year globally, (WHO, 2020).

The Program of Action of the 1994 International Conference on Population and Development (ICPD), highlights the importance of reducing adolescent pregnancy and the multiple factors underlying adolescent fertility.

Despite many interventions in the region, the rate of teenage pregnancy and other reproductive health challenges experienced by adolescent girls continue to be on the rise. The Eastern and Southern Africa region (ESA) still has the world's second-highest maternal mortality ratio at 455 deaths per 100,000 live births (UNFPA, 2017). Nearly 40% of girls between 15-19 years old have had sexual intercourse¹. Sex at this age often ends in pregnancy and has adverse effects on health, besides other socio-economic consequences

Informed by the above development CSA with support from HIVOS commissioned a desk review process aimed at understanding teenage pregnancy in Kenya in terms of magnitude and policy response. The process focussed on examining the magnitude of teenage pregnancy, existing policy response aimed at reducing cases of teenage pregnancy and the extent that regional (AU & ESA) legal and policy frameworks have influenced Kenya's policy responses to the situation in the country and why addressing teenage pregnancy is critical to achieving the country's and regional development goals.

The findings show that adolescents and youth vulnerability to sexual and reproductive health rights problems, especially teenage pregnancy and motherhood are on the increase. It further indicates that very few health facilities have the capacity to offer youth-friendly services either as stand-alone or in an integrated manner such that young people have to visit different stations to access multiple services. The review further indicates that Comprehensive Sexuality Education (CSE) is not integrated into the existing school curriculum.

Policies and other ASRH guiding documents are not only informed by national factors but also by regional experiences and thinking. Kenya's laws and policies are aligned to the international and regional SRHR instruments through AU and ESA regional blocs. However, the availability of these guiding documents on SRHR do not always translate to their dissemination and implementation due to inadequate support and goodwill in fulfilling the commitments made by governments, political leaders, policymakers, religious leaders among other stakeholders.

There exist a need to mainstream ASRH issues into health system structures, through youth responsive services across the country and integrate age-appropriate sexuality education in the existing school curriculum. Different groups in the region have been working separately thus making very few and fragmented achievements towards ASRH. The formation of an advocacy movement that can hold governments and regional political bodies accountable for the implementation of SRHR commitments, legislations, and policies is key in addressing these negative trends.

<https://data.unicef.org/topic/adolescents/demographics/>
Republic of Kenya (2018): Kenya Youth Development Policy

ABBREVIATIONS

A-ASRHR	Advocacy for Adolescent Sexual Reproductive Health and Rights
AID	Acquired Immunodeficiency Syndrome
ASRH	Adolescent Sexual Reproductive Health
ASRHR	Adolescent Sexual Reproductive Health Rights
AU	African Union
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CSA	Centre for the Study of Adolescence
CSE	Comprehensive Sexuality Education
CRC	Convention on the Rights of the Child
EAC	East African Community
ECOWAS	Economic Community of West African States
ESA	Eastern and Southern Africa
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IRC	International Rescue Committee
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
MOEST	Ministry of Education, Science and Technology
MOH	Ministry of Health
MPoA	Maputo Plan of Action
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SDI	Solemn Declaration Index
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Rights
STI	Sexually Transmitted Infections
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV&AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WRA	Women in Reproductive Age
YFS	Youth friendly Service



The 2030 Agenda for Sustainable Development cannot be achieved without investment in adolescent health and well-being, including fulfilment of its goals related to poverty, hunger, education, gender equality, water and sanitation, economic growth, human settlement, climate change and peaceful and inclusive societies (WHO, 2017)

1.0 Introduction and Background

Adolescence is a challenging phase in human development as it represents a transition from childhood to physical and psychological maturity. During this period, adolescents need to learn and develop knowledge and skills to deal with critical aspects of their health and development while their bodies mature. Young people, especially girls experience enormous health and developmental challenges including teenage pregnancy which often compromise their health and future.

Globally teenage pregnancies and teenage motherhood remain a major cause for concern for the health and well-being of adolescent girls and young women. According to the World Health Organization (WHO), about 16 million girls aged between 15 to 19 years and about one million girls younger than 15 years give birth every year globally, (WHO, 2020). Presently, the vast majority of teenage pregnancies occur in low- and middle-income countries characterized by poor health-care services leading to complications during pregnancy, birth, and postpartum phase. Pregnancy-related complications are the second cause of death among girls aged between 15 to 19 years worldwide. Additionally, it is estimated that three million teenage girls undergo unsafe abortions, which result in subsequent reproductive health challenges, including

death. The United Nations International Children's Emergency Fund (UNICEF) reported that worldwide every fifth child is born by an adolescent mother and 80% of these teenage pregnancies occur in third-world countries (UN, population fund 2018).

Teenage pregnancy and teenage motherhood were considered as normal and often socially accepted in past decades worldwide. It was absolutely common that first births took place during adolescence for much of human evolution and history. Girls married during adolescence and gave birth during their second decade of life. This kind of reproductive behaviour was socially desired and considered as normal. Although in traditional societies the majority of these pregnancies were socially desired, several studies have pointed out the enormous risks which are associated with teenage pregnancies, such as anaemia, Fistula, preterm labour and birth, urinary tract infections, preeclampsia, high rate of caesarean sections, and low birth weight infants as well as a high burden in maternal and new born mortality. Teenage pregnancies however, still also occur in high-income and developed countries and despite much better health care systems and policies, teenage pregnancies are still considered risky.²

According to UNFPA (2018), Africa has the world's highest rates of adolescent pregnancy, a factor that affects the health, education, and earning potential of millions of African girls. Approximately 12 million girls aged 15–19 years and at least 777,000 girls under 15 years give birth each year in the African region resulting in at least 10 million unintended pregnancies in Sub-Saharan Africa. Of the estimated 5.6 million abortions that occur each year among adolescent girls aged 15–19 years, 3.9 million are unsafe, contributing to maternal mortality, morbidity and lasting health problems.

Then there is the COVID-19 pandemic which has become the defining global health crisis of our time and presents the greatest challenge the world has faced since World War Two³. The pandemic is straining health systems worldwide. The rapidly increasing demand on health facilities and health care workers threatens to leave some health systems overstretched and unable to operate effectively. But the pandemic is much more than a health crisis; it has hit the world with an unprecedented socio-economic crisis. Stressing every country it touches, Kenya included, it has the potential to create devastating social, economic and political effects that will leave deep and long standing scars.

While health systems have been overwhelmed during the pandemic and economies have been shuttered, it is also recognized that women and girls have been disproportionately affected, with sexual and reproductive health (SRH) services being curtailed and gender-based violence (GBV) on the rise. Increasingly, resources are being redirected away from vital sexual and reproductive health and rights services in favour of other COVID-related responses. All over the world, women and girls face a variety of heightened risks due to the pandemic⁴. Women and girls requiring SRH services may face anxiety about exposure to the virus while seeking care – or they may forgo care entirely. Others have lost access to care all together due to movement restrictions and curbed health services. Many hospitals and health centres are reporting declines in the number of women and girls receiving critical SRH care, including antenatal services, safe delivery services and family planning.

Lockdown measures in response to COVID-19 have closed schools around the world, leaving an estimated 1.54 billion young people out of school; even fewer young people are now receiving vital Comprehensive

Sexuality Education. School closures intensified gender inequalities, especially for the poorest girls and adolescents who face a greater risk of early and forced marriage, sexual abuse and unintended pregnancy across the African region. For example in Uganda at least 4,300 teenage pregnancies were registered in the first four months of the COVID-19 lockdown by the Ministry of Gender, Labour and Social Development,⁵ while in Kenya, some preliminary data from the International Rescue Committee (IRC) suggests that in the far northern town of Lodwar, teenage pregnancies among clients of the IRC aid group nearly tripled to 625 in June-August 2020, compared with 226 in the same period a year earlier. In the nearby refugee camp of Kakuma, adolescent pregnancies among clients jumped to 51 in the March-August 2020 period, compared with only 15 in the same period in 2019⁶. The Gender Based Violence During COVID-19 Policy Paper, jointly published by the African Union Commission recommends continuous data collection on the types of violence against women and girls, including adolescent pregnancy as essential to the response and recovery from COVID-19⁷.

All the above is occurring at a time when health is a crucial component of the Sustainable Development Goals⁸. Also known as Agenda 2030, the SDGs offer a framework of 17 goals and 169 targets that provide a road map aimed at improving the lives of people throughout the world over the next 15 years. Agenda 2030 has established specific targets and indicators to measure progress toward the attainment of the SDGs. Sexual and reproductive health and rights are currently included in the SDG agenda under goals 3 and 5 with several relevant targets related to maternal health, access to sexual and reproductive health, and gender equality. The goals and targets encompass many key aspects of sexual and reproductive health and rights, including access to services, comprehensive sexuality education, ensuring reproductive rights, achieving gender equality as a matter of women's and girls' human rights, and the ability to make decisions about one's own health. United Nations Member States, Kenya included have committed to making the achievement of the SDGs a reality over a period of 15 years.

1.1

About HIVOS Project and Assistance

Although ESA countries have made commitments towards availability and access to ASRH information and services, millions of adolescent and young people continue to be denied these provisions resulting in adverse indicators including teenage pregnancy, motherhood, sexually transmitted infections and unsafe abortions. National and regional bodies have done little to enforce implementation of these policies and voices of adolescents and young people in this discourse remain restricted, and unheard. With support from HIVOS project: Accelerating access to Adolescent Sexual Reproductive Health and Rights (A-ASRHR) through Advocacy, CSA has been tasked to lead advocacy for the improvement of ASRH

outcomes among adolescents and young people in the ESA region. This is to be done through empowering young researchers with improved knowledge and skills on research and evidence generation which will be used to inform national and regional advocacy. Such evidence shall be packaged and presented as study reports, fact sheets, position papers and policy briefs to be used both for local and regional advocacy to influence policy and programming on ASRH. The A-ASRHR is being implemented by CSA in partnership with two other organizations; Latkings Zambia and SafAids Zimbabwe with funding from HIVOS. The overall goal of HIVOS project is to improve ASRH outcomes among adolescents and young people in the ESA region.

Objectives of The Project are:

1. To strengthen research capacity of 45 Young people to generate evidence for ASRH advocacy in the ESA region
2. To strengthen advocacy capacity of 45 young people to conduct advocacy on ASRHR in the ESA region
3. To develop a youth led network for advocacy with regional parliaments



2.0 Problem Statement

Africa has made significant strides in improving adolescent sexual reproductive health, especially among women, adolescent girls and young people in general. The Program of Action of the 1994 International Conference on Population and Development (ICPD), highlighted the importance of reducing adolescent pregnancy and the multiple factors underlying adolescent fertility and further urged governments to take actions to substantially reduce adolescent pregnancies. Eastern and Southern African (ESA) countries have made commitments towards availability and access to ASRH information with the adoption and commitment to International, Regional and National instruments such as the Eastern and Southern Africa (ESA) commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health services for adolescents and young people, (2013), The Abuja Declaration (2001), Addis Ababa Declaration on Population and Development (2013), AU's Agenda 2063, the Maputo Protocol (2007) and SDGs (Agenda 2030)

Despite all these interventions in the region, the rate of teenage pregnancy and other reproductive health challenges continue to be on the rise. The Eastern and Southern Africa region (ESA) still suffers as the world's second worst maternal mortality ratio at 455 deaths per 100,000 live births (UNFPA, 2017). Furthermore, UNAIDS has estimated that adolescents and young women made up one in four of all new HIV infections (UNAIDS, 2017). Millions of children in ESA countries continue to be denied comprehensive reproductive health care services resulting in adverse indicators such as early and unintended pregnancies, high HIV infections and AIDS related death and unsafe abortion. National and regional bodies have done little to enforce implementation of the commitments they have made and voices of adolescents and young people in this discourse remain restricted, and unheard.

Kenya is a signatory and state party to the many international and regional human rights instruments that guarantee the right to sexual and reproductive health. Subsequently the Government of Kenya has made remarkable progress in domesticating the relevant international and regional conventions, agreements and protocols into several country-specific legislations and policies and putting in place institutional frameworks to address SRH challenges facing adolescent girls specifically and women in general. However, evidence exists to show that this supportive policy

environment in the country has not translated into improved ASRHR indicators.

Sexual activity among the youth in Kenya begins quite early in their life. Nearly 40% of girls between 15-19 years old have had sexual intercourse⁹. Sex at this age often ends in pregnancy and has adverse effects on health, besides other socio-economic consequences. Early childbearing can increase risks for the new born as well as young mothers. Studies have shown that most adolescent pregnancies (around 90%) are unplanned putting them at greater risk of experiencing complications arising from unsafe abortions and child birth. Their children are also at a higher risk of dying in infancy, a part from being faced with complications. Adolescent mothers (ages 10–19 years) face higher risks of eclampsia, puerperal endometritis, and systemic infections than women aged 20 to 24 years, and babies born to adolescent mothers face higher risks of low birth weight, preterm delivery and severe neonatal conditions (WHO, 2020). According the Ministry of Health (2016)¹⁰, about 20,000 girls seek care for abortion related complications each year, while unsafe abortion remains the leading cause of maternal mortality and morbidity especially among girls below 20 years in Kenya. High level of unprotected sexual activity exposes the female youth to the risk of contracting STIs, including HIV and AIDS. Socio-economic impacts of early pregnancy and motherhood include loss of education opportunities, low participation and representation in decision-making and

loss of employment/labour participation opportunities which cumulatively leads to higher risk of living in poverty among other problems.

The COVID-19 pandemic (since March 2020 when the first positive case was reported in Kenya) has exacerbated the challenges in enrolment and retention of girls in school and created temporary disruption that led to suspension of school activities. The situation contributed to negative coping mechanisms among adolescent girls, such as child marriage, alcohol and drug use and entering toxic relationships due to the loss of educational support systems such as girls' peer networks and teachers' guidance. The situation further has led to long-term negative impacts on girls' access to opportunities and resources to improve their lives and ultimately, on their educational, economic, and health outcomes.¹¹ Adolescents and young persons experience the effects of the pandemic in ways that reflect their unique developmental and cohort situations. The need for quality SRH information, including

contraceptive services for young people is even greater now considering the challenges they already face in accessing reproductive health information and services at health facilities and pharmacies. The problem of teenage pregnancy is bound to escalate with the current crisis.

Social consequences for unmarried pregnant adolescents may include stigma, rejection or violence by partners, parents and peers. Girls who become pregnant before the age of 18 years are more likely to experience violence within a marriage or partnership¹². Pregnancy is the second most common reason for adolescent girls' dropping out of secondary school in Kenya, with 13,000 teenage girls leaving school for this reason each year. This is because, teenage pregnancies not only affect the reproductive health of young women but also cause negative social and economic consequences to the individuals, their households and communities. The State of Kenya Population, 2020 summarizes the scenario vividly thus:

“

“When a girl is married, her rights are violated. Her schooling ends. Childbearing in childhood begins. Opportunities evaporate. Doors to the future slam shut. Sometimes she is given away. Sometimes she is traded for something of value. Sometimes she is a burden off-loaded onto someone else. Sometimes she is handed over to someone deemed to be capable of ensuring her security. But rarely, if ever, is she the one who makes the decision”¹³.

(The State of Kenya Population, 2020)

”

Normally, marriage is immediately followed by the onset of motherhood. An analysis of women aged 20 – 49 years in Kenya who got married when they were children shows that about two-thirds commenced motherhood when they were still children (age below 18) (KNBS, 2015). On a macro level teenage pregnancy also exerts economic cost with a country losing out on the annual income a young woman would

have earned over her lifetime, if she had not had an early pregnancy. Overall, Teenage births lower opportunities for human capital development and disempowers young women from meaningful participation in policy and decision making on ASRHR.

Efforts by the Government of Kenya to address teenage pregnancy through legal, policy and strategic frameworks exist and

are well documented. However, whether these efforts are bearing fruit continue to be the biggest question in the country. Evidence exists to show that some of such efforts are resisted by parents, religious leaders, political leaders and other stakeholders despite the mounting evidence that young people are initiating sex early. Proven interventions like

age appropriate sexuality education (AACSE) are also often dismissed with the view that they would encourage young people to indulge in sex. In order to address this challenge decisively, it is important that evidence plays a central role in determining interventions that can stump out the problem from its root cause (AFIDEP, 2020).

2.1 Rationale, Goal and Objectives of the Study

2.1.1 Rationale

According to WHO (2017), a critical, overarching reason to invest in the health of adolescents is that adolescents, like all people, have fundamental rights to life, development, the highest achievable standards of health and access to health services. These are supported by global human rights instruments, to which almost all countries are signatories. More specifically, it is becoming increasingly clear that promoting and protecting adolescent health will lead to greater public health, economic and demographic benefits. Investments in adolescent health bring a triple dividend of health benefits¹⁴.

Nationally, as at 2019, women of reproductive age (15-49) make up 25% of the total population (N = app. 12 million). Of these 41% (5 million) are young women aged 15-24, while adolescent girls (age 15-19) constitute 22% (2.6 million) of all women in reproductive age (WRA)¹⁵. Therefore the SRHR needs of Kenya's adolescent girls can no longer be ignored (more so by the duty bearers) as this population category constitutes nearly one-quarter of the total population of

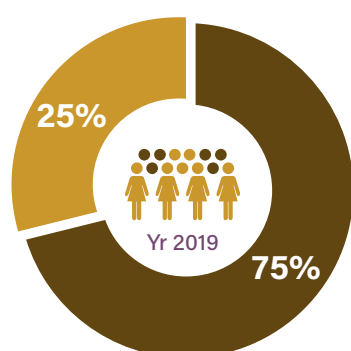
WRA. This is made even more urgent by the fact that adolescent or teenage pregnancy and childbearing has become common in Kenya. Kenya's adolescent birth rate is 96 per 1,000 women. According to the Kenya Demographic and Health Survey (2014), 18% of (i.e. nearly 1 in 5) girls age 15-19 have already begun child bearing with the proportions increasing rapidly with age, from about 3% among girls aged 15 to 40% among those aged 19. This trend of teenage pregnancy has been fairly consistent for more than two decades with little change in prevalence between 1993 and 2014 – at 18%.

This study aims to understand teenage pregnancy in Kenya in terms of magnitude and policy response. It has already been established that adolescent girls in Kenya suffer some of the poorest reproductive health outcomes such as early and unintended pregnancies caused by limited access to comprehensive sexuality education, information and services, peer pressure, poverty, drugs and substance abuse, dominant heterosexual masculinity norms leading to gender injustice, child/

2.1

early marriages etc. The underlying causes of these vulnerabilities facing adolescent girls and young women are hinged on community, societal, institutional and political hindrances. The institutional hindrances include inadequate or poor quality SRHR services friendly to young people; inadequate CSE for adolescents; low knowledge of SRHR legislation and inadequate dissemination and implementation of existing international and regional instruments and national policies and guidelines. Societal barriers include harmful cultural beliefs and practices and low knowledge about existing legislations and policies in place to promote ASRHR. In order to address rampant teenage pregnancy in Kenya

specifically and in the ESA region more decisively, it is important that evidence plays a central role to examine policy and programmatic interventions that would adequately address the root causes and reduce the magnitude of the problem, if not eliminate it altogether. It is therefore expected that the findings of this study will identify and clarify the weak links that hinder access to and provision of information and services to young people. Additionally the findings will help in informing the Legal framework and policies around teenage pregnancies and motherhood and document some of the best practices and challenges in enforcing the existing laws and/or implementing the identified policies.



Approx. 12 million

Women of reproductive age (15-49) make up 25% of the total population

Approx. 5 million

41% of women in reproductive age are young women aged 15-24

App. 2.6 million

Adolescent girls (age 15-19) constitute 22% of all women in reproductive age

2.1

2.1.2 Purpose

Provide crucial information and knowledge to inform regional and national AYSRH advocacy interventions for improving the AYSRH outcomes including reduction of teenage pregnancies in East and Southern Africa.

2.1.3 Study Objectives

1. To examine the legal and policy environment that guarantees ASRHR including the prevention of teenage pregnancies in Kenya;
2. To examine the magnitude of teenage pregnancy in Kenya;
3. To examine the existing approaches and strategies that address teenage pregnancy in Kenya and identify gaps and areas that need improvement in addressing teenage pregnancies
4. To establish the linkage (or connection) between the national and) regional policy interventions to address teenage pregnancy.

Key questions for this desk review were:

1. What is the magnitude of teenage pregnancy in Kenya?
2. What are the policy responses aimed at reducing teenage pregnancy?
3. To what extent have the regional (AU & ESA) legal and policy frameworks and instruments influenced Kenya's policy responses to teenage pregnancy in the country; and,
4. Why is addressing teenage pregnancy critical to achieving the country's development goals?

3.0. Methodology



The study is fully reliant on secondary data sources and therefore applied a comprehensive desk review approach of the available documentation relevant to the subject matter. This was done through a review of the existing literature (Legislations, policies, guidelines, national surveys and peer reviewed publications) relevant to Teenage Pregnancy and Motherhood. The literature search was conducted using Google Scholar, PubMed, Cochrane Database and MEDLINE. Other documents reviewed included: published global, regional, programme documents and institutional publications to help put into context the situation on Teenage Pregnancy and motherhood in Kenya. The findings presented in this report are therefore a result of the review efforts as described. (Full list of documents reviewed are at the end of the document - *See Appendix 1*)

4.0 Findings and Discussion

4.1 The Legal and Policy Environment

Sexual and reproductive health is a fundamental human right as well as human development issue that states must strive to fulfil. This right is guaranteed in various international and regional human rights instruments as well as national laws and policies. Sections 6.1.1 and 6.1.2 below examine the legal and policy landscape with regard to ASRH and rights in both the ESA region and Kenya. The analysis of the policy landscape aims to determine the linkage between national and regional legal and policy instruments and the operationalization of the same.

4.1.1 Regional instruments

According to the United Nations International Conference on Population and Development- Cairo (ICPD) of 1994



“Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents.” (ICPD-1994)



Since the 1994 ICPD, African countries under the auspices of African Union and other regional blocks (such as EAC, ECOWAS, SADC, etc.) have converged to interpret and put into action the ICPD resolutions and guide member states in the operationalization of the same. This review focuses on AU and ESA instruments that have a bearing on SRHR in general and ASRHR in particular. A comprehensive scan revealed the existence of the following main regional policy frameworks: The Abuja Declaration (2001), CARMMA (2009); The Maputo Plan of Action (2016-2030); The EAC-SRH Bill, 2017 and Africa Young Women Manifesto (2019). The sections below summarize the main tenets of the cited instruments.

1. The Abuja Declaration: In April 2001, the African Union countries met in Abuja and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support. However, this pledge to increase government health funding is yet to be implemented by most of the African States, Kenya included while national health budget allocations to SRH are hardly known.

2. The Maputo Plan of Action: There have been reviews and advancements within the AU aspirations after the 2001 Abuja Declaration, key among them being the Maputo Plan of Action (MPoA) for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights. The MPoA Framework provides a unanimous recognition (by Member States) that poor SRH is a leading killer in Africa and identified unsafe abortion in particular as one of the 10 major issues for AU Member States to address. They would do this by instituting health legislation and policies for improved access to reproductive, maternal, new-born, child and adolescent health services, including the removal of legal, regulatory and policy barriers limiting women and young girls' access to safe abortion.

The MPoA has since undergone reviews from 2007 – 2015 and has been extended into the current MPoA 2016 – 2030, which seeks to take the continent toward the goal of universal access to comprehensive SRH services in Africa beyond 2015. It is a long-term plan, built on nine action areas: political commitment, leadership and governance; health legislation; health financing/ investments; health services strengthening/human resource development; partnerships and collaborations; information and education; accountability/monitoring and evaluation; investment in the vulnerable and marginalized populations; and improved adolescent and youth sexual and reproductive health and rights. These elements of sexual and reproductive health and rights include adolescent sexual and reproductive health; maternal health and new-born care; safe abortion care; and family planning, among others. This extension provides an opportunity for the African continent to propel action and generate political will and support for the attainment of the ICPD aspirations and SDGs on sexual and reproductive health. While recognizing the need to emphasize sexual and reproductive health and rights, the MPoA 2016-2030 further states that “this must be built into and on an effective health system with sufficient infrastructural, financial and human resources.”¹⁶ The MPoA concludes that “African leaders have a civic obligation to respond to the sexual and reproductive health needs and rights of their people.

The Action Plan is a clear demonstration of AU member states' commitment to advance sexual and reproductive health and rights in Africa.” It is essential for the Member States to mobilize domestic resources to support health programmes, including complying with the Abuja health target and MPoA commitments. It is clear that the MPoA has an overarching goal for African governments, Civil Society Organizations, the private sector and all multi sector development partners to join forces and double efforts to jointly effectively implement continental policy framework on SRHR so as to end maternal, new-born and adolescents deaths, teenage pregnancies, improve access to contraceptives for all, reduce levels of unsafe abortions, end child marriages, eradicate harmful cultural practices such as female genital mutilation amongst other issues. The Maputo protocol gives adolescents and young people priority and the urgency to access reproductive health services, access to RH information and education, increasing health financing etc. All AU member states are expected to follow and implement the Maputo Plan of Action to improve the health of adolescents and the health and economic status of member countries.

3. The East Africa Community SRH Bill 2017): The EAC SRH Bill of 2017, once it becomes an Act, aims to protect the sexual and reproductive health and rights for all persons including adolescent girls in all the partner states of EAC. Some of the objectives of the Bill include:

- (i) to prevent unwanted pregnancies, risky/unsafe abortions and sexually transmitted infections;
- (ii) to ensure that there is access to quality and comprehensive SRH care services to all people; and,

(iii) to provide a framework for protection and advancement of SRHR for all persons, amongst others.

The Bill further states: ‘Every individual has a right to seek and receive age appropriate sexual and reproductive health information in any form, either orally, written or in print, in art or through any other medium of choice, subject to restrictions in law’. The Bill also covers the right to education for girls who get pregnant and the right to comprehensive RH information/education.

4. The East Africa Gender Policy (2018): Despite tremendous progress made in education and learning across the EAC member states, the East Africa Gender Policy (2018) recognizes teenage pregnancy and early marriage, sexual reproductive health challenges as major impediments in school retention and completion rates particularly among girls and young women.¹⁷

5. Africa Young Women Manifesto (2019): The Africa Young Women Manifesto recognizes and demands for removal of barriers to young women and girls’ education including poverty, early and forced marriage, early and unintended pregnancy, lack of sanitation and menstrual hygiene facilities, introduction and implementation of effective Comprehensive Sexuality Education courses and programs in schools to educate young women on their health and how their choices affect their own well-being and that of others¹⁸

6. Other Regional Policy Initiatives: Other existing/on-going regional initiatives within the AU framework relevant to this review and study are: the launch of the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009, with a similar aim as that of the Maputo Plan of Action—to reduce maternal mortality and ensure universal access to reproductive health; the Solemn Declaration Index (SDI) on Gender Equality in Africa (2004); and the 2014 Agenda 2063. The SDI on Gender Equality in Africa was adopted with the aim of promoting gender equality and women’s empowerment in Africa. Agenda 2063 is a strategic framework for the socio-economic transformation of the continent over the next 50 years. It builds on and seeks to accelerate the implementation of past and existing continental initiatives for growth and sustainable development. It aspires to, among other things, promote respect for human rights and people-driven development while unleashing the potential of women and youth. Since 2013, Kenya has been a signatory to the joint Ministerial Commitment on Comprehensive Sexuality Education (CSE) for the provision of comprehensive and rights-based sex education starting in primary school. The aim of the Commitment is to strengthen HIV prevention, treatment, care and support, and SRHR efforts in Eastern and Southern Africa by ensuring access to good quality, comprehensive, life skills-based HIV and sexuality education (CSE) and youth-friendly sexual and reproductive health services for all adolescents and young people, recognizing each country’s socio-cultural context.

4.1

4.1.2 Kenya’s National legal and Policy Framework

Being a state party to the various international and regional human rights instruments that guarantee the right to sexual and reproductive health, the Government of Kenya

has responded by putting in place various legislative and policy frameworks to align the country’s aspirations to those of the global and regional communities. Such global and

regional instruments include, but not limited to: Convention on the Rights of the Child (CRC) ratified in 1990, Program of Action of the International Conference on Population and Development (ICPD, 1994), the Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in Eastern and Southern Africa (ESA, 2013), the extended Maputo Plan of Action 2016-2030 and the SDGs (or 2030 Agenda) set in 2015 by the UN General Assembly. To this extent, the Constitution of Kenya 2010, for the first time, guarantees the right to health care including reproductive health.¹⁹

Nationally, Sexual Reproductive Health (SRH) issues are addressed within various legislative and policy frameworks. These include the Constitution of Kenya (2010), Sexual Offences Act (2006), Children's Act (2001), Counter Trafficking in Persons Act (2010), Prohibition of FGM Act (2011), Persons With Disabilities Act (2003), HIV and AIDS Prevention and Control Act (2006), Marriage Act (2014), Kenya Vision 2030, Sessional Paper No. 3 on Population Policy for National Development (2012), National Reproductive Health Policy (2007), National Youth Policy (2007, 2018), Kenya National Adolescent Sexual and Reproductive Health Policy (2015), National Guidelines for Provision of Youth Friendly Services (2016), Gender Policy (2011), Gender and Education Policy (2007), Kenya Health Policy (2012-2030), Kenya Health Sector Strategic and Investment Plan (2013-2017), Education Sector Policy on HIV and AIDS (2013), National School Health Policy (2018), National Gender-Based Violence (2014), National Guidelines for School Re-entry in Early Learning and Basic Education 2019. Other laws that the Kenya government has enacted to address reproductive health and particularly the adolescent and young people SRHR include: The Children Act 2001, The Sexual Offences Act 2006 and Basic Education Act. The main focus areas in these

instruments revolve around access, equity, quality, capacity and institutional frameworks for implementation.

Operationally, the management of reproductive health in Kenya, including Adolescent SRH, is under the Division of Family Health in the Department of Preventive and Promotive Health of the Ministry of Health. The main management instrument for the National RH programme is the National Reproductive Health (RH) Policy 2007 whose goal is to improve reproductive health status of all people in Kenya by increasing equitable access and improving quality, efficiency and effectiveness of service delivery at all levels. The main management instrument for Adolescent SRH is the National Adolescent Sexual and Reproductive Health Policy (2015) which is operationalized through the National ASRH Implementation Framework to guide counties to translate the policy into action. Within this Policy Framework, the county governments are called upon to domesticate the policies and develop their own county-specific strategies and action plans to address the unique ASRH issues and needs of their respective counties.

While the implementation and coordination of reproductive health including adolescent SRH policies are directly overseen by the Ministry of Health, the Government of Kenya recognizes that AYSRHR is not just a health issue but an issue that must be addressed in a multi-sectoral manner with nearly all sectors – both state and non-state - getting involved for optimal results. The roles of each sector in addressing adolescent health and development needs are spelt out in both the RH and ASRH policies

Analysis of some of the key relevant legal and policy frameworks are presented in the sections below.

4.1

4.1.3 The Education Sector legal and policy instruments

1. The Constitution of Kenya 2010: This is the highest law of the land and is therefore very broad in its guidance on issues. No details would be expected from it and therefore cannot be faulted for mentioning the term ‘reproductive health’ only once with regard to the Bill of Rights at section 43(1)(a) which states that ‘Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care’. It therefore remains the responsibility of the health sector policy makers, agencies and actors to interpret and strategically operationalize and translate these rights into reality.

2. The Health Act 2017: The Health Act reaffirms the Constitution and states in Part II that ‘Every person has a right to reproductive health care which includes [among others] the right of men and women of reproductive age to be informed about, and to have access to reproductive health services including to safe, effective, affordable and acceptable family planning services...’ and therefore calls on the National health system to devise and implement measures to promote health and to counter influences having an adverse effect on the health of the people including—a comprehensive programme to advance reproductive health including effective family planning services (among other RH issues).

3. Kenya Vision 2030: Vision 2030, Kenya’s long term development blue-print articulates the country’s development goals including health goals – i.e. ‘to provide equitable and affordable healthcare to the highest quality standards’. Guidance for the operationalization of the Vision 2030 is usually articulated in 5-year Medium Term Plans (MTP) which list family planning (FP) as one of the high impact strategies and related interventions for achieving flagship projects for the health sector’s priority focus areas. The medium term plans also recognize reproductive health as key to achieving gender equality for the realization of women’s potential in all sectors with special mention of agriculture, education and sexual reproductive health (SRH) rights. It ought to be noted that all the existing health related national policies, strategies and plans, including those related to SRH are underpinned upon Vision 2030.

4. Kenya Health Policy 2012-2030: This very high level health sector policy gives guidance to the sector in totality. It has the goal of ‘**attaining the highest possible health standards in a manner responsive to the population needs**’. The policy aims to achieve this goal through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans.

5. Sessional Paper No. 3 of 2012 on Population Policy for National Development (Currently under review): This Policy identifies rapid population growth and a youthful population structure as key issues that will pose challenges in the realization of Vision 2030, and provides the overall framework with key policy measures to be undertaken to address the critical population management issues. One of the objectives stated in the policy is to provide equitable and affordable quality reproductive health services including family planning. In addition to the issues around equity in SRH/FP service provision and access, the policy also cites inadequate access to SRH/FP services delivery points, insecurity of contraceptive commodities attributed to over-dependence on donor funding and poor distribution logistics as some of the challenges affecting FP services delivery. The policy further recommends its implementation be undertaken within the broader framework of Vision 2030 and the 2010 Constitutional dispensation and stresses the need for cross sectoral, multidimensional approaches involving the Government, FBOs, NGOs, Private Sector and communities for provision of quality integrated youth friendly SRH education and services.

6. Kenya Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Investment Framework, 2016: This policy framework on RMNCAH was developed in 2016 with the Vision as:

A Kenya where there are no preventable deaths of women, new-born or children and; no preventable still-births; where every pregnancy is wanted, every birth celebrated and accounted for; and where women, babies, children and adolescents are free of HIV/AIDS, survive, thrive and reach their full social and economic potential.

This vision is aligned to Kenya's development goals as spelt out in 'Vision 2030', which aims to provide equitable and affordable health care by focusing on ensuring universal access to quality preventive and curative health care. The Investment Framework is informed by the guiding principles of respecting human and reproductive health rights (as enshrined in the Kenyan Constitution), promoting equity and gender equality, ensuring a responsive health system to client needs, and leadership and ownership at both national and county levels.

7. National RH Policy, 2007: Just like other health policies, this policy cites RH as a core component of Kenya Essential Package for Health (KEPH). The goal of the policy is to improve reproductive health status of all people in Kenya by increasing equitable access and improving quality, efficiency and effectiveness of service delivery at all levels. But this goal was set amid a host of challenges, key of which included: Inadequate funding for implementation of a national RH programme; disparities in health resource allocation; and lack of specific interventions targeting resources to the poor and the 'hard to reach' populations. The result of inadequate funding has been a weak health system, inefficient integration and poor quality of service delivery. The Policy identifies the two main barriers to accessing Adolescent SRH services by the young people – i.e. (i) Inadequate access by adolescents and youth to reproductive health information and youth-friendly services; and (ii) Inadequate focus of reproductive health programmes to adolescent and youth with varied needs. The Policy proposes the following key actions to address the identified barriers: (i) Ensure that adolescents and youth have full access to sexual and reproductive health information and services; (ii) Establish high-quality, comprehensive and integrated youth-friendly reproductive health services that also address the diverse needs of adolescents and youth, including those infected with or affected by HIV, youth with disabilities and the hard to reach; (iii) Promote a multi-sectoral approach in addressing adolescent sexual and reproductive health needs; and (iv) Strengthen partnerships and referral with NGOs and FBOs working with youth, with emphasis on those who are hard to reach. The Policy spells out the roles of all the sectors that will contribute to achieving the stated policy goal and objectives.

8. National Adolescent Sexual and Reproductive Health Policy 2015: In 2015, Kenya developed a National Adolescent Sexual Reproductive Health Policy (ASRH). The Policy aims to enhance the sexual and reproductive health of adolescents in Kenya to contribute in realising adolescents' full potential, and contribute to national development. It aspires to bring Adolescent Sexual and Reproductive Health and Rights issues into the mainstream of health and development. One of the key areas that the national ASRH Policy focuses on (among other ASRH issues) is teen pregnancy. The Policy identifies and addresses itself to a number of priority areas and issues that affect the SRHR of adolescents in Kenya, namely: sexual debut, contraception and fertility; HIV&AIDS and STIs; sexual abuse and violence; drug and substance abuse; harmful practices (FGM, child marriage) and marginalized and vulnerable adolescents. Strategies for addressing these priority areas include: promotion of legal and socio-cultural environment for provision

of quality SRH information and services to adolescent, ensuring equitable access and gender equity and equality as well as promoting inter-sectoral coordination and strengthening data collection, analysis and utilization of age/sex disaggregated data on adolescents. Attainment of these broad objectives would result in: attaining adolescent SRHR, increased access to ASRH information and age-appropriate comprehensive sexuality education (AACSE), reduction of the burden of STIs including HIV and HPV, reduction of early and unintended pregnancies, reduction of harmful practices and addressing special SRHR needs of marginalized and vulnerable adolescent.

To address the issue of teenage pregnancy, the Policy has lined up a number of priority actions revolving around accuracy of information and quality of services provided to adolescents; linkage and access to skilled care; male involvement; quality post abortion care (PAC) services; implementing school-re-entry policy for pregnant adolescents; law enforcement and social protection. The Policy is also very transparent about the need to increase access to ASRH information and Age Appropriate Comprehensive Sexuality Education (AACSE) for both out-of- and in-school adolescents and young persons in general. The Policy further spells out the strategies for ensuring the provision of CSE as follows:

1. Strengthening ASRH information and AACSE programs for out-of-school and in-school adolescents;
2. Supporting the provision of age-appropriate ASRH information;
3. Facilitating innovative approaches including utilization of digital platforms to enhance access to SRH information;
4. Building the capacity of health care providers to provide SRH information to adolescents;
5. Leveraging on existing community health structures to provide ASRH information and AACSE;
6. Enhancing the linkage between government ministries in charge of education and health (MoEST and MoH); and
7. Promoting appropriate costing and earmarking of programs targeting adolescents in national and county budgets.

The Policy also spells out the institutional arrangements for its implementation which embraces a multi-sectoral approach and outlines the roles and responsibilities of each sector – state and non-state. To operationalize the Policy, the government, through the Ministry of Health developed two more key policy instruments – i.e. (i) the Implementation framework which spelt out the strategies and broad activities for the national and county levels of government to undertake to achieve the objectives of the Policy in order to reduce teenage pregnancy in the country, and, (ii) the National Guidelines for the Provision of Adolescent and Youth Friendly Services in Kenya (2016) with the goal of improving availability, accessibility, acceptability and use of quality sexual and reproductive health services by adolescents and youth seeking services. The Guidelines recommend a minimum package of youth-friendly SRH services using 4 models – i.e. (i) community based (ii) clinic-based, (iii) school based and (iv) virtual based models.

4.1

4.1.3 The Education Sector legal and policy instruments

Of special mention is the recognition that of all the sectors tasked with the implementation of the ASRH-related policies to contribute to the MOH efforts, the education sector's role has been given a central role especially with regard to the prevention of teenage pregnancy and ensuring that girls of school going age are in school, pregnant or not. The National Education Curriculum emphasizes the need to produce an engaged, empowered, and ethical



Youth-friendly SRH services using 4 models

citizens through nurturing every learner's potential. This is in line with the aspirations of the Constitution of Kenya 2010, Kenya Vision 2030, the Basic Education Act (2013) and SDG 4 on inclusive education. Despite the government's initiatives to promote quality and affordable education to all Kenyan children, access, retention, transition and completion particularly among adolescent girls remain a challenge and a concern. Although the number of learners enrolled in school has improved over the years, school dropout rates are significant, leading to low transition and completion rates and rising illiteracy levels.

The Basic Education Sector Act 2013, and related policies: This Act of Parliament commits the Education Sector to ensure that the school re-entry guidelines steer the development and implementation of interventions for learners who drop out of school for one reason or the other. This part of the Act is being operationalized through the National Guidelines for School Re-entry in Early Learning and Basic Education (2019). The guidelines focus on learners who drop out of school for various reasons, including but not limited to early pregnancies, drug and substance abuse, HIV and AIDS, gender based violence, inhibitive cultural practices, child labour, special needs and disabilities. In the case of learners who become pregnant while in school, the Guidelines have spelt out the steps to follow to ensure the learner does not drop out of the school system as long as she is within the mandatory school going age.

The foregoing confirms that Kenya has a favourable policy and legal context for addressing teenage pregnancy within the context of ASRH and Rights. However, despite this favourable policy environment, teenage pregnancy and other ASRHR indicators continue to lag behind as presented and discussed in the following sections of the report.

4.2 Magnitude of Teenage pregnancy

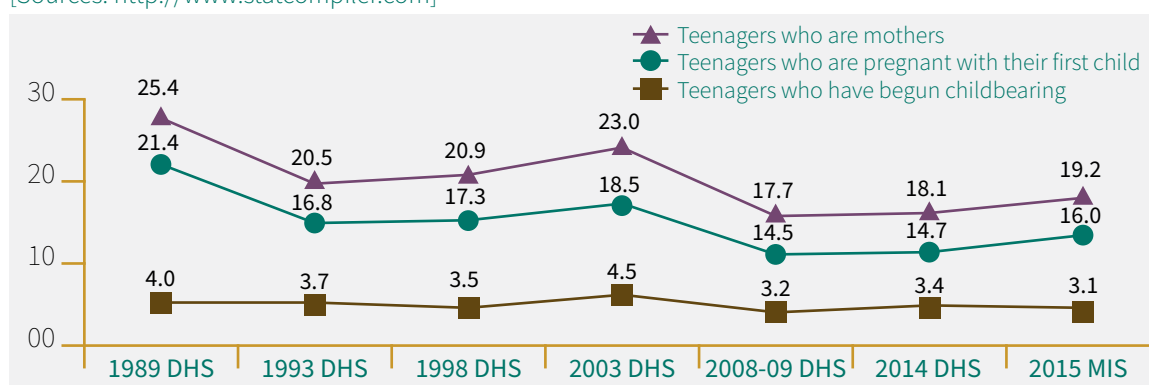
Teen pregnancy is a major challenge for socioeconomic development because it deprives our young girls the opportunity to further their education and attain their career goals. It also exposes them and their children to major health risks. According to the World Health Organisation, “pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally.” This is because adolescent girls have unique health and development needs, yet they are faced with enormous challenges of early sexual debut, unplanned pregnancy, and higher number of births. 2015 Global Accelerated Action for the Health of Adolescents (WHO AA-HA!) Guidance²⁰ states that maternal conditions are one of the top five leading causes of death worldwide for adolescent females aged 10-19.

Early sexuality which often result in teenage pregnancy is a critical concern from several perspectives: potential health harm young women face such as incidence of obstetric fistula; their children being at a higher risk of not celebrating their first birth day; loss of education opportunities and risk of not participating in labour force leading to higher risk of living in poverty among others. As a result, the Program of Action of the 1994 International Conference on Population and Development (ICPD), highlighted the importance of reducing adolescent pregnancy and the multiple factors underlying adolescent fertility. The Program of Action further recommended that governments take action to substantially reduce adolescent pregnancies. Kenya, like all other AU Member States, has made a commitment to achieve the Sustainable Development Goals (SDGs) within the specified 15-year period – i.e. by 2030. The government’s commitment to end teenage pregnancy was reiterated in 2020 during the Nairobi Summit on ICPD25. This has been followed by an aggressive mobilization of high-level intergovernmental committees to develop and implement proven solutions.

The gravity of high teenage pregnancy is not new in Kenya. Data from the Demographic and Health Surveys show that almost 2 out of 10 girls between the ages of 15 and 19 are reported to be pregnant or have had a child already. This trend has been fairly consistent for more than two decades with little change in prevalence between 1993 and 2014. Figure 1.1 shows trends in indicators for teenage motherhood in Kenya since 1989. The proportion of teenagers who have begun childbearing slightly increased by about 1.5 percentage points since 2008. About 19 percent of teenagers have begun childbearing. A critical concern with regard to childbearing is the unchanging birth rate among teenagers in age group 15-19.

Figure 1.1: Trends in indicators for teenage childbearing 1989-2015

[Sources: <http://www.statcompiler.com>]



Teenage pregnancy is high in counties across the country, and has remained so for some time now despite the periodic outcry when numbers on teenage pregnancy are released. However, it is important to note that the adolescent birth rates are not uniformly distributed in the country and may be linked to socio cultural norms especially early marriage. Twenty-three (23) counties out of forty seven (47) have adolescent birth rate (ABR) of 100 and above births per 1000. The highest adolescent birth rates are in Narok (225), Homabay (178), Samburu (170) Tana River (144), Migori, (136) Turkana (136) and West Pokot (133). Counties with high poverty levels also tend to have high adolescent birth rates and relatively higher under five mortality rate. In terms of regions Nyanza, Rift Valley and Coast regions lead in teenage pregnancy with adolescent girls (15-19) who have begun child bearing being 22.2%, 21.2% and 20.8% respectively. Regional differentials in teenage fertility is shown on the table below.

Table 1. Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child and percentage who have begun childbearing, by county, Kenya 2014 [Source: KDHS 2014]

Region	% Have had a live birth	% pregnant with 1 st child	% begun childbearing
Nyanza	19.2	3.0	22.2
Rift Valley	17.0	4.3	21.2
Coast	16.6	4.3	20.8
Nairobi	13.1	4.3	17.4
Western	14.1	2.7	16.8
Eastern	12.1	2.3	14.4
North Eastern	8.7	3.5	12.2
Central	7.7	2.7	10.4
Total	14.1	3.4	18.1

Attention is also beginning to focus on adolescent fertility and childbearing among children (age 10-14). According to the draft Population Policy for National Development, there are nearly 6,400 births per year among girls aged 10-14. Kenya could see more maternal deaths if trends of teenage pregnancies are not checked and curbed.

4.2 4.2.1 Factors responsible for high levels of teenage pregnancies in Kenya

Early Sexual Debut: Sexual activity is high among adolescents and youth in Kenya and begins early. KDHS data show that median age at first sexual intercourse in Kenya is 18 years for women and 17.4 years for men. Though the median age at first sexual intercourse has been increasing (from 16 in 1993 to 18 in 2014), about 12% of girls and 22% of boys reported to have had sex by the age of 15. Similarly, 37 percent of girls and 44 percent of boys aged 15 to 19 years have had sex.

Inadequate Access to and Use of Contraceptive Information and Services: Contraceptive prevalence is lowest among 15-19-year olds and is known to increase with education. Nationally only 40% of adolescents have access to contraceptives; slightly more than half (53.5%) of young people aged 20-24 have access to contraceptives.²¹ Women with an unmet need for family planning represent an important group as they often have to face unintended pregnancies – particularly among young women. Limited knowledge of sexual and reproductive health information and lack of access to contraception lead to unplanned pregnancy among women. Adolescents in Kenya have a high unmet need for contraceptives. 23% of girls aged 15-19 years want to delay pregnancy or stop having children but are not using a modern contraceptive due to lack of access.

Inadequate Access to Education: While there has been increased primary school enrolment in recent years in Kenya, the concern at the moment is with regard to the internal efficiency of primary education and particularly the ability to retain pupils until they complete the eight year cycle. Nationally, the country is doing well on primary school enrolment even though regional and gender disparities exist in access, completion and transition in the education system. 88% of children in the official primary school age are enrolled in primary school and the gender gap in primary school is low. But less than a half (47%) of children in the official secondary school-age were enrolled in secondary school.²² While the transition rate for both boys and girls is still low, there is a high dropout for girls in secondary school compared to boys. Net enrolment rates significantly drop, especially for girls, from primary to secondary school.²³

Child Marriage: Underage marriage is a human rights violation because it poses health risks and limits the girls' options. One of the major contributors to the high teenage fertility rate in the country is early marriage. The Laws of Kenya define a Child as: **any human being under the age of eighteen years**, and further defines early marriage as: **marriage or cohabitation with a child or any arrangement made for such marriage or cohabitation**.²⁴ Simply put, child marriage is defined as any legal or customary union involving a person below the age of 18. This definition draws from various conventions, treaties, and international agreements. According to UNICEF (2017)²⁵, **Kenya** has the 20th highest absolute number of **child** brides in the world. Although child marriage is illegal in Kenya and considered a human rights violation, available data shows that despite legal pronouncements, the proportion marrying by age 15 has not reduced since 1990s. According to the KDHS (2014), 4.4 percent of girls aged 20-24 had married by age 15 and 23 percent were married by age 18. The KDHS (2014) further indicates that child marriage is a major cause of teenage pregnancy. The government of Kenya has always been keen on reducing adolescent birth rates and therefore the earliest age at legal marriage has been set at age 18 for both boys and girls. This means that marriage at ages below age 18 is considered illegal and harmful to the rights of teenagers especially girls. A key recommendation here is that policy interventions need to be put in place to accelerate progress to end child marriage.

Female Genital Mutilation (FGM):FGM affects the physical and psychological health of girls and women; decreases their attendance and performance at school; fails to meet their gender equality rights; and risks their lives at the time of FGM, at marriage and during childbirth. FGM is linked to obstetric and gynaecological complications and long-term negative effects on women's wellbeing. It is also linked to girl child marriage and early pregnancy.

Kenya has made progress in accelerating abandonment of FGM. Various Demographic Health Surveys conducted in Kenya since 1998 indicate a reducing trend in the practice of FGM in 15- to 49-year-olds across the country from 37.6% (1998) to 32.2% (2003) to 27.1% (2008-9) and 21% (2014/15). The practice has therefore reduced by around 15% in 15 years.²⁶

However, FGM is still quite prevalent in some communities in Kenya. Girls who have undergone FGM are more likely to get married and start childbearing early. FGM also has a relationship with other issues such as girls not completing their education and having poor literacy; getting into early or arranged marriage; and promoting the spread of HIV infection.

Drug and substance use: Drug abuse is one of the top problems confronting Kenya today especially among the youth. Incidences of drug and alcohol abuse and related anti-social behaviour have tremendously increased in recent years raising concerns to the government, parents, teachers, NGOs and all other relevant agencies. Use of drugs has led to many health problems in the youth, especially among the secondary school students. Drugs and substance use is known to lead to irresponsible and risky sexual behaviour as they affect judgment and decision making. The user is unable to assert himself or herself especially when it comes to saying no to unprotected sex thus resulting to exposures to sexually transmitted infections and/or unplanned pregnancies. According to NACADA (2017), sex resulting from the influence of alcohol and drug abuse was reported. Nearly 5% of children aged 10-14 years reported having engaged in sexual intercourse due to alcohol and drug use/abuse. Out of these, nearly 80% did not use a condom during the sexual encounter thereby exposing themselves to early/unplanned pregnancy and STIs.²⁷ In addition, drug use is closely tied to being truant and dropping out of school. Those using drugs are mostly likely to skip school.²⁸

Poverty: Poverty and material deprivation have also been found to push girls into activities that expose them to sexual exploitation and survival sex in exchange for money and food.²⁹ In 2003, the Kenya government issued what it hoped would be the final call to realize universal primary education. It cushioned this call on the 2001 Children Act Cap 586 of the Laws of Kenya which asserts that “every child is entitled to free basic education”. In a country where 36.1% of the population lives below the poverty line, this goal will be difficult to attain. In some parts of Kenya, parents still marry off their daughters at a young age for prestige and a source of income and to also avoid the possibility of them getting pregnant out of wedlock while at their fathers’ homes.

Lack of guidance from parents: The 2008 CSA³⁰ study revealed that problems in parent-child relationships may also alienate adolescents and encourage them to seek comfort, acceptance and consolation through sexual activity among their peers or older partners. Kenyan society does not allow a more open dialogue on sexuality between adolescents and adults. The study showed that in as much as girls would have liked to discuss sexuality with their parents, most parents were shy and often adopted a controlling approach and scare tactics which did not work for both parents and the teenagers.

Media Influence: Exposure to suggestive and/or explicit media, films, magazines and websites may also influence adolescent sexual behaviour. In recent years, improvement in communication has made access to information much easier than before – especially with internet technology. Media has expanded with easy internet access - apart from the emergence of the many FM radio stations and television channels – where young people are able to access information on a whole range of issues. While this is a positive development, it has also made access to pornographic and sexually explicit material quite easy.

4.2

4.2.2 Teenage pregnancy during COVID-19 crises

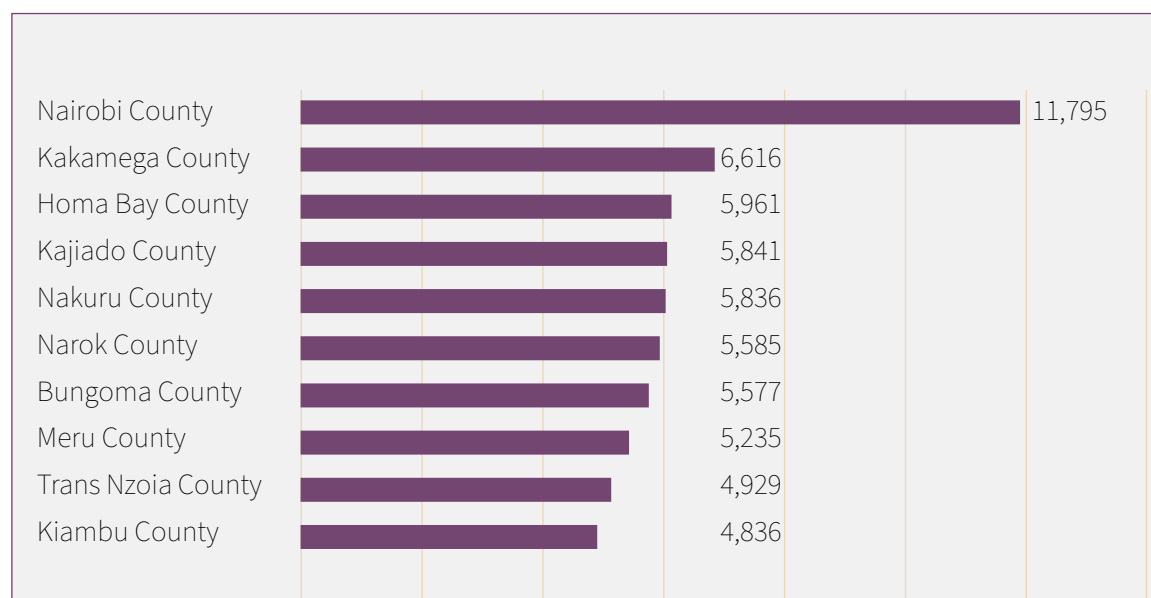
The coronavirus COVID-19 pandemic is the defining global health crisis of our time and presents the greatest challenge we have faced since World War Two³¹. All over the world, women and girls face a variety of heightened risks due to the pandemic³². Women and girls requiring sexual and reproductive health services may face anxiety about exposure to the virus while seeking care – or they may forgo care entirely. Others have lost access to care all together due to movement restrictions and curbed health services. Many hospitals and health centres in Kenya are reporting declines in the number of women and girls receiving critical sexual and reproductive health care, including antenatal services, safe delivery services and family planning³³.

In their report, *Living Under Lockdown*, Plan International (2020)³⁴ observed that pregnancy and childbirth related complications for adolescent girls (15-19) tend to increase substantially in crisis settings, such as during the 2020 CORONA-19 pandemic. This happens for two main reasons: resources being redirected away for vital SRHR services in favour of COVID-related responses, and, lockdown measures in response to COVID-19 have closed schools living more than 1 billion young people around the world out of school thus being denied access to CSE normally given in schools. All too often when shifting from offline to online learning, CSE falls by the wayside and isn't included in learning packages. And even where it is, with connectivity still being a luxury rather than a right and an ever-widening digital gender gap, girls and young women from marginalised, poorer households are the least likely to be able to access information through digital platforms.

Kenya, along with the rest of the world is currently responding to the COVID-19 pandemic.

How the COVID-19 pandemic will affect the different aspects of our lives is continuously being documented and discussed. The economic effects of COVID-19 and the response of the Kenyan government has been well documented. The COVID-19 pandemic has exacerbated the challenges in enrolment and retention of girls in school; temporarily disrupted school activities and escalated the risk of early and forced marriage, sexual abuse and unintended pregnancy across the country. The Plan International report further states that being out of school increases teenage girls' vulnerabilities to not just early and unintended pregnancies but also to early marriages or contraction of Sexually Transmitted Infections (STIs) including HIV & AIDS. In addition with schools closed, young girls are shut up at homes where they are faced with an increased risk of sexual exploitation and gender-based violence all of which may result in unintended pregnancies. Barely four months of the Covid-19 pandemic there were reports of an upsurge in the number of teenage pregnancy cases in the country as shown in Figure 2.

Fig.2. Teenage Pregnancy (10-19 yrs) – Jan-May 2020. [Source:<http://www.peah.it/2020/07/8605/>]



The Ministry of Education has put in place strategies to ensure continuity of education through distance online learning delivered through radio, television and the Internet. However, these strategies have further widened the inequality gap, as learners from poor, vulnerable, and marginalized households are unable to benefit from continued learning through these platforms due to lack of access³⁵. School closure also stopped the provision of school meals and sanitary towels, which children from disadvantaged families rely on significantly. This raises the risks of young girls engaging in transactional sex in order to gain not only access to these essential needs but also to support their families. There is evidence that links poverty, lack of family support, and transactional sex.

Consequences of teenage pregnancy have been widely documented and disseminated; (e.g. Gebreselassie, 2005; MOH, 2013 & 2018; PRB, 2015). These literature point to the fact that teenage pregnancy puts young women in harm's way including: unsafe abortion^{36,37,38}, school girl drop out^{39,40} and early marriage. This picture is poignantly captured in the following UNFPA (2017) statement:

“

“When a girl becomes pregnant, her life can change radically. Her education may end, and her job prospects diminish. She becomes more vulnerable to poverty and exclusion, and her health often suffers.” (UNFPA-2017)

”

4.3 Strategies, Approaches and Gaps in addressing Teenage pregnancy in Kenya

This review focuses on the analysis of only two current intervention strategies for addressing teenage pregnancy in Kenya – i.e. youth friendly service provision and comprehensive sexuality education.

4.3.1 Provision of Youth friendly services

Over the years there has been an emergence of evidence-based research directed towards the development, implementation, and assessment of youth-friendly services (YFS) to improve the delivery of sexual and reproductive health services for adolescents and young people with the aim of ending teenage pregnancies and motherhood. According to the World Health Organization (WHO, 2001) Global Consultation on Adolescents and Youth, health services for adolescents and young people should aim to achieve at least one of three goals: (1) provide a supportive environment, (2) improve reproductive health knowledge, attitudes, skills and behaviours, and (3) increase utilization of health and related services. The WHO guidelines for providing YFS recommends services that are accessible, acceptable, equitable, appropriate and effective. (WHO, 2001).

The teenage pregnancy-related targets set by Kenya's National ASRH Policy revolve around 3 indicators – i.e. age at sexual debut among 12-14 year olds, prevalence of teenage pregnancy and contraceptive prevalence (CPR) among adolescents (15-19). The Policy aspires to: increase age at sexual debut among the 12-14 year olds from age 10 in 2015 to age 15 in 2020 and age 18 by 2025; lower prevalence of teenage pregnancy among adolescents (15-19) from 18% in 2015 to 12% in 2020 and 10% by 2025; and, increase CPR among adolescents (15-19) from 40.2% in 2015 to 50% in 2020 and 55% by 2025. Subsequently, the government put in place intervention strategies as spelt out in national documents – implementation frameworks, guidelines and protocols – to fast track the attainment of the set targets. Key among these are the National Guidelines for the Provision of Adolescent and Youth Friendly Services developed by the Government in 2016.

The Guidelines recognize the need to provide the full range of contraceptive and maternal health services for those at risk of unintended pregnancy or who are pregnant and at risk of maternal morbidities and mortality. In the Guidelines, the Government acknowledges that Adolescents and Youth-friendly services (AYFS) are meant to help young people overcome barriers to access quality sexual and reproductive health care services and that AYFS providers should be able to respond to the needs of young people, remove their fears, respect their concerns, confidentiality and provide the services within an environment that suit their preferences. They explicitly spell out the characteristics of adolescent and youth friendly services as:

Equitable (i.e. all adolescents and youth, without discrimination, are able to obtain the health services they need),

Accessible (All adolescents and youth are able to obtain the health services that are provided),

Acceptable (Health services are provided in ways that meet the diverse expectations of adolescents and youth clients),

Appropriate (Health services that adolescents and youth need are provided), and

Effective (The right health services are provided in the right way and make a positive

contribution to the health of adolescents and youth). The services should be provided within a welcoming environment so that youth are able to return for the services and refer their friends. **These aspirations are aligned to** the WHO (2001) Guidelines for providing adolescent and youth friendly services.

The Guidelines further recommend a minimum package of youth-friendly SRH services using four (4) models of service delivery as described below: – i.e. (i) community based (ii) clinic-based, (iii) school based, and (iv) virtual based.

1. Community based

Services and information are offered to adolescents and youth within the community/non-medical settings e.g. in youth centres, outreaches, churches, youth groups, community based groups, support groups, peer-mentorship

2. Clinic-based

Services and information are offered to adolescents and youth within/based on health facility setting. This includes; public, private, social franchise, faith-based, and NGO health facilities. Institutions of higher learning e.g. universities, colleges and vocational training centres that have clinics within their setting can adapt clinical based model

3. School-based

Services and information are offered to adolescents and youth within the school setting.

4. Virtual based

Services and information are offered to adolescents and youth within the virtual space or digital platforms e.g. in eHealth, mHealth, tele-medicine, warm/ hotlines.

The YFS Provision Guidelines give a well-documented and explanatory step by step guide on how youth friendly services should be structured – the infrastructure, type of services and who should provide those services. Young people working to provide youth friendly services as peer educators within the YFS spaces report that it is easier for teenagers to relate and speak with people of their age sets. However, even with the recommended structures in place, most existing YFS spaces have insufficient infrastructure and capacity to efficiently run the spaces. The main sources of ASRH information and services is the public health sector facilities, even though the facilities have not been fully or adequately prepared to be responsive to the varied needs of adolescents – in terms of provider skills and facility infrastructure. Coverage of AYFS has remained unacceptably low at 7%⁴¹ in 2010 and slightly increased to 10% in 2013⁴². The stated target for YFS coverage – according to the ASRH Policy, 2015 – is to increase facilities that offer YFS from 10% in 2013 to 30% in 2020 and to 50% by 2025.

Some of the challenges experienced with providing youth friendly services in Kenya include:

1. Distances to where the YFS spaces are located pose a challenge especially for the teenagers who come from very far and in poverty stricken areas and hence access to services is a major challenge. Worse case is when the teenagers are pregnant it's harder for them to get the services⁴³.
2. There are inadequate resources for effective implementation of the ASRH Policy which includes the provision of YFS in the country. This translates into poor resourced facilities

(equipment, supplies and commodities), inadequate skilled personnel to provide YFSs, etc. Even so there are no clear advocacy strategies or mechanisms for resource mobilization other than the identification of the advocacy target structures and bodies for possible attainment of increased resources for ASRH programming in the county. Inadequate investment in the health infrastructure and technology to affect the effectiveness of the programme in matters to do with confidentiality and privacy.

3. Most YFS centres are not integrated in that one has to visit different stations in order to access multiple services where need arises. A comprehensive package of SRHR interventions should be fully integrated as part of the existing Universal Health Coverage and as national strategies, policies and programs of action - SRHR services are available to some extent. However, the SRHR services, particularly for pregnant teenagers and mothers need to be more health promotive, preventive and cost effective. In addition, dissemination of information regarding the provision of SRHR services and the available policies is inadequate especially both to the service providers, other cadre of policy implementers and the communities.

4.3

4.3.2 Comprehensive Sexuality Education

Sexuality education is one of the key components in a multifaceted approach to address the high need for sexual and reproductive health information and services among adolescents. The World Health Organization (WHO) defines Comprehensive sexuality education (CSE) as a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. CSE ensures healthy sexual and reproductive lives for young people including prevention of teenage pregnancies and sexually transmitted infections (STIs). CSE aims to equip children and adolescents with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives.

Sexuality education is more than the instruction of children and adolescents on

anatomy and the physiology of biological sex and reproduction. It covers healthy sexual development, gender identity, interpersonal relationships, affection, sexual development, intimacy, and body image for all adolescents, including adolescents with disabilities, chronic health conditions, and other special needs. There is evidence to show that comprehensive sexuality education (CSE) that is life skills based, age appropriate, culturally and gender sensitive, and scientifically accurate provides young people with knowledge and skills to make informed decisions about their sexuality⁴⁴. By embracing a holistic vision of sexuality and sexual behaviour, which goes beyond a focus on prevention of pregnancy and sexually transmitted infections (STIs) including HIV&AIDS, age appropriate CSE enables children and young people to acquire accurate information, explore and nurture positive values and attitudes and develop life skills that encourage critical thinking, communication, negotiation and decision making. Developing a healthy sexuality is a

key developmental milestone for all children and adolescents that depends on acquiring information and forming attitudes, beliefs, and values about consent, sexual orientation, gender identity, relationships, and intimacy⁴⁵.

In 2013, the Kenyan government signed a declaration in which it committed to scaling up comprehensive rights-based sexuality education beginning in primary school. To this extent, the provision of sexuality education to adolescents nationally is supported by several national policies and guidelines, although these focus on life skills and HIV and lack comprehensiveness. Education-sector policies have largely promoted HIV prevention education and focused on abstinence, resulting in a limited scope of topics offered in school.

Comprehensive sexuality education is critical as it offers the opportunity to reach adolescent girls with important information and skills to take control of their lives and pursue a brighter future for themselves, their families, and their communities. But the provision of comprehensive sex education in Kenya remains a hotly-contested issue by religious leaders, who hold great sway on such matters, and it is yet to be rolled out in line with National Adolescent Sexual and Reproductive Health policy⁴⁶. In addition, Kenyan society does not allow a more open dialogue on sexuality between adolescents and adults, while most parents use scare tactics to prevent their children from engaging in sexual activity⁴⁷.

Despite the government's efforts to integrate CSE in the Kenyan school curriculum, the process has been faced with challenges such as fierce opposition from conservative and religious groups. This leaves the teachers constrained to focus largely on HIV prevention and abstinence leaving the students with limited knowledge on reproductive and sexual health, and unable to make informed decisions on the same (Wadekar, 2020). This is further corroborated by Sidze's findings⁴⁸ that some messages conveyed to students were reportedly fear-inducing and judgmental or

focused on abstinence, emphasizing that sex is dangerous and immoral for young people. There is support for sexuality education from the Ministry of Health, but education sector policies have largely promoted an abstinence-only approach, which has resulted in a lack of comprehensiveness in the range of topics offered in the curricula. There is also strong support for teaching sexuality education among principals, teachers and students alike, but the topics integrated into compulsory and examinable subjects are limited in scope, and there is little incentive for teachers and students to prioritize them.⁴⁹ In a 2019 study by the Guttmacher Institute, only 13 percent of the students surveyed knew how to use contraceptives while 66 percent wanted to learn more (Karuga, 2019).

Other challenges to provision of CSE in schools include the fact that the teachers also face significant challenges in the classroom, ranging from lack of time, materials or resources to perceived community opposition, their own discomfort, and lack of knowledge or training on the topics. As observed by Ogolla and Ondia (2019) most teachers are not trained in CSE, and CSE is not included in the curriculum. Personal biases, opinions and values related to sexuality education threaten the delivery of CSE. Resource materials are also unavailable. Their study concluded that while teachers acknowledged the need for CSE, its delivery is severely inhibited by lack of training, non-inclusion of CSE in the curriculum, inadequate time allocation for CSE lessons, and lack of teaching resources⁵⁰. Another major challenge has been to reconcile rights-based approaches that emphasize adolescents' right to comprehensive SRH information and services with deeply rooted conservative approaches that stigmatize or denounce certain aspects of SRH education and services, such as improving access to condoms.

There is also lack of proper implementation strategy for incorporation of CSE into the existing school curriculum to effectively

ensure the young learners receive the knowledge on their SRHR. The teachers who are supposed to pass the knowledge to the learners' lack proper training on CSE as the training, as planned by the government, doesn't actually happen. This leaves them limited to only share the little knowledge they have and in turn ineffectiveness of the knowledge passed to the learners. This means that individual teachers make decisions on their own regarding what and when to teach CSE. This discretion implies holding back the much needed SRHR information from the learners, teaching abstinence as the only way of preventing pregnancy or cancelling sexuality education sessions altogether. Teachers' choices about the CSE program were linked to lack of guidance on teaching of the curriculum, especially on how to integrate sexuality education into existing subjects. Limited prioritization of CSE in the educational sector was observed⁵¹.

The incompatibility of CSE with local norms and understandings about adolescent sexuality combined with teacher-parent role dilemmas emerged as problematic in implementing the policy. Limited ownership of the new curriculum further undermined teachers' motivation to actively include CSE in daily teaching activities. Another notable challenge identified is the centralization of education in Kenya. In theory centralization is supposed to ensure national investments in teacher training and curriculum development, wider coverage of programs and continuity of content delivered in schools across the country. However, studies show that a decentralized approach to school-based sexuality education has several advantages – i.e. allows for programs to be adapted to different contexts, would reduce bureaucratic delays and barriers, and encourage counties to prioritize the needs of adolescents and young people unique to their environment⁵².

4.4 Linkages between National and ESA regional efforts

As discussed in the foregoing, Kenya's commitment to addressing the SRHR issues affecting adolescents is demonstrated by the fact that the country is a signatory to several international and regional human rights treaties and declarations. The Government has in turn translated and domesticated such protocols by enacting and putting in place relevant legislations, policies, strategic plans and implementation frameworks to guide the ASRHR interventions. These national policies and strategic plans⁵³ have explicitly recognized teenage pregnancy as a socio-economic, demographic and health problem. The linkage between Kenya's national ASRHR-related legislations and policies with the regional (AU and ESA) instruments has been demonstrated in the above analysis. It is clear that Kenya's legislations and policies

are aligned to and therefore informed by the international and regional instruments.





5.0 Conclusions & Recommendations

This document review sought to: examine and discuss ASRHR legal and policy frameworks in the ESA region and Kenya and establish the linkages, examine and discuss the magnitude of teen pregnancy in Kenya and identify and make recommendations on areas that need improvement to address teenage pregnancy in Kenya. The review was guided by four questions around establishing the magnitude of teenage pregnancy in Kenya, policy responses for reduction of teenage pregnancy, extent to which Kenya's policy frameworks are aligned to the regional instruments and why it is critical to address teenage pregnancy to development

The following sections of this report discuss some of the interventions that have been put in place to implement the ASRHR-related legislations and policies. Gaps and/or areas for improvement are also highlighted.

Drawing inferences from the findings of this study report and under the key objectives; the legal and policy frameworks that touch on prevention/reduction of teenage pregnancies, the magnitude of the problem in Kenya, strategies and the approaches that have been put in place to address the problem, the report concludes and recommends as follows:

5.1 Conclusions

1. To examine the legal and policy environment that guarantees ASRHR including the prevention of teenage pregnancies and motherhood in Kenya.

The Desk review has established that there are commendable legal guidelines and policies that guarantee the realization of ASRH and rights in both the ESA region and Kenya. Most notable, the Regional and National Sexual Reproductive Health (SRH) issues are addressed within various Countries' legislative and policy frameworks thus creating ownership and by extension sustainability of the same. The existence of the relevant policy documents in Kenya confirms that there exists undoubtable resolve to address the existing negative ASRH indicators and provides enabling environment for doing so. On the contrary, teenage pregnancy and other poor ASRHR outcomes continue to lag behind as mentioned in the previous sections of the report. Even though Kenya has made tremendous effort in putting in place a multi sectoral approach towards addressing the SRHR issues of adolescents, there still lacks a vibrant structure (e.g. ASRHR technical working group) that continuously takes stock of the progress and addresses the emerging concerns in a timely manner.

2. To examine the magnitude of teenage pregnancy in Kenya and the approaches and strategies in place to address the problem.

The review has also established that Kenya, like other sub-Sahara African countries continue to battle the ever rising cases of teenage pregnancies. In fact, the teenage pregnancy trend has remained consistent for more than two decades with little change in prevalence. The COVID-19 pandemic has further exposed the underbelly of Kenya's Health system in dealing with teenage pregnancy if the recent upsurge of cases is something to go by, despite the above listed strategies like the YFSs, CSE provision in schools which seek to address the problem. The review notes that very few health facilities have the capacity to offer youth friendly services either as stand-alone spaces or in an integrated manner such that young people have to visit different stations in order to access multiple services. Further, the review established that CSE is not integrated into the existing school curriculum; a strategy that would guarantee its adoption and use by the teachers for the benefit of adolescents and young people in school setup.

3. To identify gaps and areas for improvement and provide recommendations for addressing teenage pregnancies which will be useful to the government, civil society groups and other stakeholders focusing on the health and development of young people

This study has identified several gaps in implementation and dissemination of National and regional adolescent and youth SRH policies which continue to hinder success towards ending teenage pregnancies in Eastern and Southern African Countries. The study report shows that there's availability of good policies, guidelines and laws on SRHR of young people necessary to ensure that their sexual and reproductive health rights are observed and that they are protected from any form of harm (physical, emotional and mental). However, the availability of these guiding documents on SRHR do not always translate to their dissemination and implementation due to inadequate support and goodwill in fulfilling the commitments made by governments, political leaders, policy makers, religious leaders etc. Because of this, the intended purpose of the policies are not met and teenage pregnancies continue to be on the rise in Kenya. This study has also shown that young people prefer to access reproductive health services and information

in youth friendly settings without any judgment or discrimination. Yet health facilities that offer youth friendly services are still very few in the country.

4. To examine the linkage between National and East and Southern regional policy interventions to address teenage pregnancy

Despite inadequate enforcement and implementation of the existing relevant legislations and policy guidelines in Kenya, the review has established that the said laws and policies are aligned to the international and regional SRHR instruments specifically through the African Union and Eastern and Southern Africa regional bloc. Policies and other ASRH guiding documents are not only informed by national factors but also by regional experiences and thinking.

5.2 Recommendations

To guarantee a reduction in the negative SRHR outcomes faced by adolescents in their SRHR such as teenage pregnancies, this study recommends the following:

1. The Kenyan Ministry of Health should create a more vibrant and deliberate Adolescents Technical Working Group that will work with civil society organizations, adolescents and young people, religious groups, parents and other key stakeholders who will advise on, track and monitor the implementation of the existing ASRHR policies, guidelines and protocols and provide feedback for strengthening ASRHR programmes and services. County governments also need to domesticate the existing ASRHR legislations and policies to develop strategies that resonate with the unique needs of their adolescent populations and put in place relevant interventions to address those needs.
2. In order to address the increasing rates of teenage pregnancy, this study recommends that the Kenyan Government should integrate youth friendly services into all the health facilities throughout the country which will improve access to ASRHR information and services that respond to the adolescent and young people's SRH needs.
3. The Kenyan government needs to integrate an age appropriate sexuality education in the existing School Curriculum together with an implementation strategy which will ensure the appropriate teacher training in delivery of CSE to enhance learners' acquisition of critical knowledge about their sexuality to help them in making decisions about their own SRHR.
4. Young people and civil society groups in the East and Southern African region form advocacy movements and create platforms which can hold governments and regional political bodies accountable on the implementation of the regional SRHR commitments legislations and policies. Different groups in the region have been working separately thus making very few and fragmented achievements towards AYSRHR. Of special mention is the need to jointly advocate to the EAC to pass the Regional SRH Bill of 2017 into an Act which has been pending since 2017. It is anticipated that once the Act is in place, it will inform and accelerate the enacting of the Kenyan RH Bill which currently is pending and faces continued uncertainty over the past 2018 years.

Appendix 1: Documents reviewed

- United Nations International Conference on Population and Development-Cairo (ICPD) of 1994
- The Abuja Declaration 2001
- Campaign for Accelerated Maternal Mortality in Africa (CARMMA) 2009-2019
- The Maputo Plan of Action 2016-2030
- The EAC- SRH Act, 2017
- Africa Young Women Manifesto 2019
- The East Africa Commission SRH Bill 2017
- The East Africa Gender Policy 2018
- The Constitution of Kenya 2010
- Kenya Vision 2030
- Sessional Paper No. 3 of 2012 on Population Policy for National Development (currently under review)
- National Youth Policy (2018)
- National RH Policy (2007)
- Kenya National Adolescents Sexual and Reproductive Health Policy (2015)
- National Guidelines for Provision of Youth Friendly Services (2016)
- National School Health Policy)- Ensures that children receive assistance in acquiring positive values and life skills in school 2009.
- National Guidelines for School Re-entry in Early Learning and Basic Education 2019
- Basic Education Act (2013)
- National Surveys – KDHS (2014/15); NAYS; National Alcohol and Drug Abuse (NADA) Survey [ADD MORE WHERE APPLICABLE]
- Government Reports – e.g. The State of Kenya Population 2020
- Global and Regional reports (UN, WHO, AU, ESA)
- Institutional/organizational research reports on teenage pregnancy and motherhood

Endnotes

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Annex 1:

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UNDERSTANDING TEENAGE PREGNANCY IN KENYA: THE MAGNITUDE AND POLICY INTERVENTIONS

ACCELERATING ACCESS TO ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND
RIGHTS IN EASTERN AND SOUTHERN AFRICA THROUGH ADVOCACY

