



# Teenage pregnancy and motherhood situation in Kenya: The County burden and driving factors

## Background

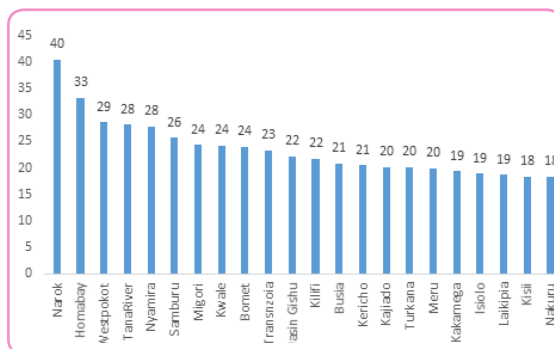
The teenage pregnancy and motherhood rate in Kenya stands at 18%<sup>1</sup>. This implies that about 1 in every 5 teenage girls between the ages of 15-19 years, have either had a live birth or are pregnant with their first child. The rate increases rapidly with age from 3% among girls aged 15, to 40% among girls aged 19. The situation varies by County with some counties being disproportionately affected than the others.

The Kenya Demographic and Health Survey (KDHS) report (2014) further indicates that teenage pregnancy and motherhood rates have remained unchanged since 2008, implying that many girls continue to drop out of school; continue to experience health related challenges including mortality and morbidity due to birth related complications and unsafe abortion; and are in some instances forced into early marriages.

The net effect of this is that, the prospects of girls securing descent economic opportunities is greatly compromised, and this in turn jeopardizes the country's potential of reaping the demographic dividend.

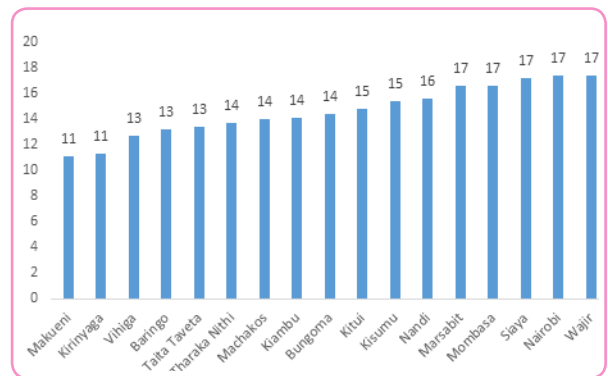
## County Burden of Teenage Pregnancy and Motherhood In Kenya

Figure 1: Counties with the highest burden of teenage pregnancy and motherhood (Above National average of 18%)



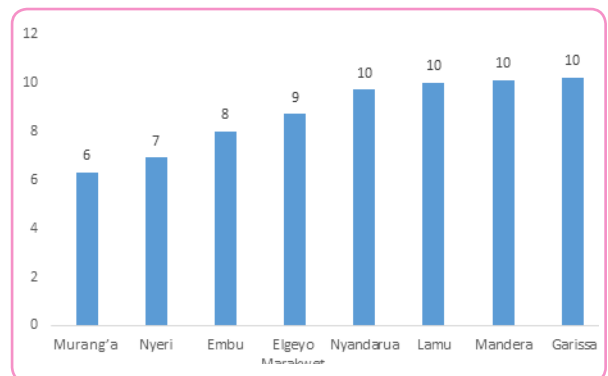
Source: KDHS, 2014

Figure 2: Counties with moderate rates of teenage pregnancy and motherhood (Between 11-17%)



Source: KDHS, 2014

Figure 3: Counties with the lowest burden of teenage pregnancy and motherhood (10% and below)



Source: KDHS, 2014

## Drivers of Teenage Pregnancy and Motherhood

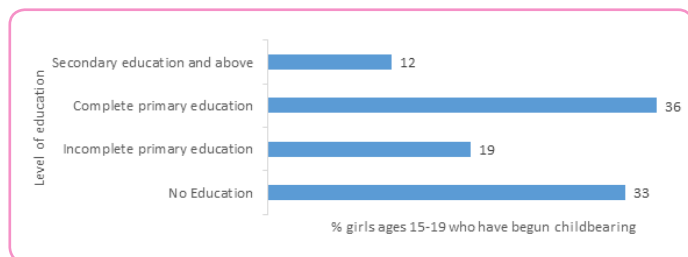
Teenage pregnancy is driven by a number of factors including but not limited to: lack of education including education on sexual and reproductive health; poverty; early sexual initiation; harmful cultural practices such as child marriages; sexual abuse/violence and barriers to access to sexual and reproductive health services.

### a) Lack of education including education on sexual and reproductive health

Education is a social vaccine and is associated with positive health outcomes. Studies have consistently shown that education attainment has a strong effect on health behaviors and attitudes. Accordingly, teenage girls with no education or those with primary education only, are more likely to begin childbearing compared to those with secondary education and above. The KDHS (2014) indicates that 33% of teenage girls (15-19 years) with no education had begun childbearing compared to 12% of girls with secondary or higher education.

Schools equip adolescents with basic information on sexual and reproductive health (SRH)<sup>2</sup>. Moreover, schools provide a safety net/protective environment to adolescents, thereby reducing their vulnerabilities to teenage pregnancy, early childbearing and other SRH risks.

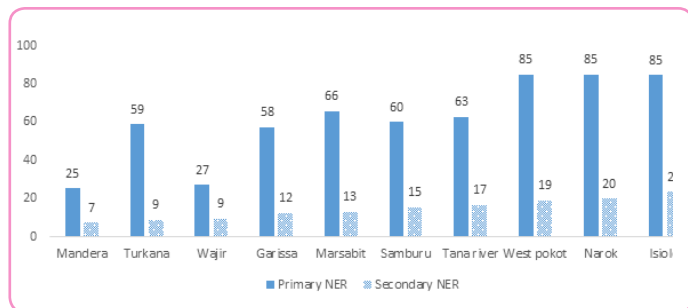
Figure 4: Level of Education vs Teenage pregnancy (%)



Source: KDHS, 2014

Poor school enrolment, retention, transition and completion rates compromise education attainment and can be attributed to high teenage pregnancy rates in some counties. A case in point is Narok, West Pokot, Tana River, Samburu and Turkana which have low transition rates from primary to secondary school (Figure 5). An exception to this is former North Eastern Counties which have fairly moderate rates of teenage pregnancy and motherhood despite having low school enrolment and transition rates. This can be attributed to other factors.

Figure 5: Counties with lowest secondary net enrolment rate (%)



2014 Basic Education Statistical Booklet. 2015

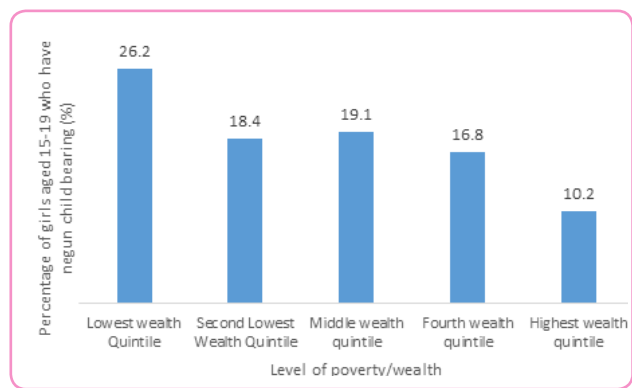
Whereas schools provide information on sexuality and sexual reproductive health, the information is inadequate and does not to fully respond to contemporary challenges facing learners<sup>3</sup>. Parents on the other hand are not providing sufficient guidance to adolescents leaving this important role to teachers, uninformed peers, and the internet. Preliminary findings from the National Adolescent and Youth Survey Report (NAYS) (2015) suggests that parents have been negligent and have failed to provide proper guidance to the adolescents.

### b) Poverty

According to KDHS (2014), teenagers from the poorest households were more likely to experience teenage pregnancy and motherhood (26%) compared to teenagers from wealthiest backgrounds (10%). This can be attributed to the effects of poverty on education attainment, as well daily subsistence at household level. Poverty

compromises school enrolment, retention, transition and completion thereby predisposing girls to early sexual relationships including early marriages. Further, some girls are driven into sex to either meet their personal financial needs or those of their families<sup>3</sup>. Preliminary findings from the NAYS (2015) identifies boda boda riders, touts, teachers, and fisher men as some of the perpetrators of teenage pregnancy in some counties, due to their “financial capabilities”<sup>4</sup>. The survey further links poverty to school absenteeism, where girls are forced into child labor for lack of school fees, or are forced to remain at home during menstruation, for lack of sanitary pads.

Figure 6: Poverty vs teenage pregnancy (%)

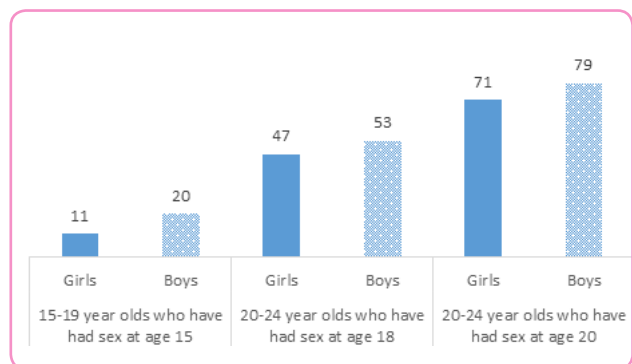


Source: KDHS, 2014

### c) Early initiation of sex

Early initiation of sex increases the likelihood of teenage pregnancy and pre-disposes adolescents to other numerous health risks. According to KDHS (2014), 37.3% of teenage girls and 40.6% of teenage boys between the ages of 15-19, have had their first sexual intercourse. The number of young people initiating sexual activity increases as one approaches age 20. Further, boys initiate sexual activity earlier than girls. Early initiation of sex can be attributed to a number of factors including but not limited to peer pressure; influence of new media; drug and substance use; sexual coercion, poverty and child marriages. This is coupled with young people’s lack of requisite knowledge, skills, values, and attitudes to make informed decisions about their sexuality and relationships.

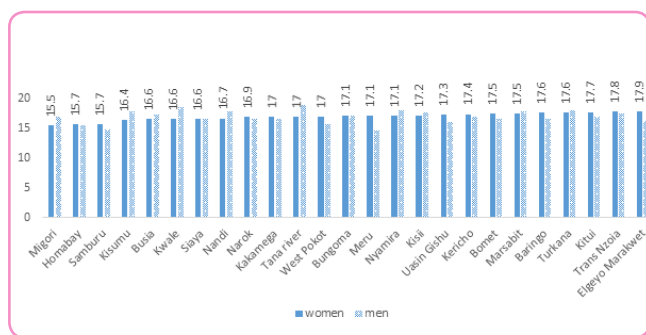
Figure 7: Age at first sex among young people (%)



Source: KDHS, 2014

Variations also exist with regards to sexual initiation by adolescents in different counties. Notably, in more than half of the Counties in Kenya, the median age of sexual debut of women between the age of 20-49 is younger than age 18 (Figure 8). This means that half of women of reproductive age in those Counties started engaging in sex before age 18. Furthermore, in 9 Counties, about half of which are located in the former Nyanza province, women’s median age of sexual debut ranges between 15 and 17 years.

Figure 8: Counties with median age at 1st sex among women (ages 20-49) younger than age 18

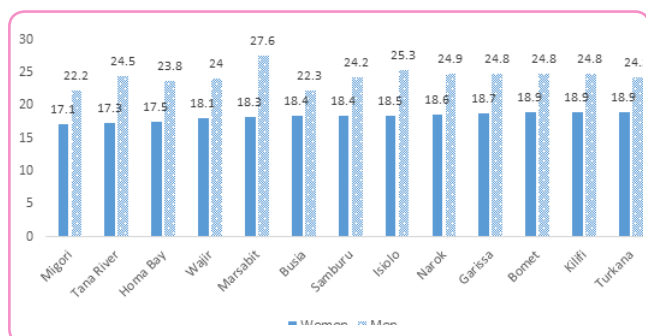


Source: KDHS, 2014

### d) Child/ Early marriages

Child marriages expose girls to teenage pregnancy. According to KDHS (2014), 13.6% of adolescent girls and 0.7% of adolescent boys between the ages of 15-19 years are married. In addition, the median age at first marriage for women age 25-49 and men age 30-54 in Kenya is 20 years and 25 years, respectively. This means that half of women and men of reproductive age married by age 20 and 25, respectively. However, in more than half of Counties in Kenya, the median age at first marriage of women is younger than 20 years (Figure). In three Counties (Migori, Tana River and Homa Bay), women tend to marry before age 18 years.

Figure 9: Counties with median age at 1st marriage among women (ages 25-49) younger than age 20



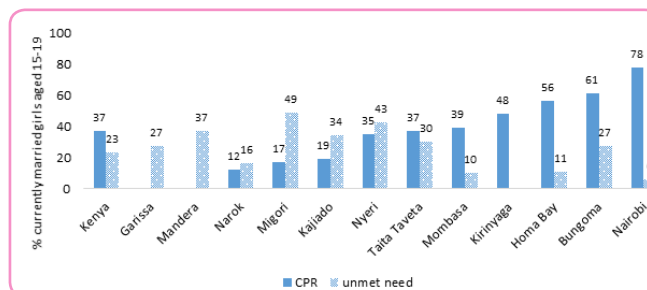
Source: KDHS, 2014

### e) Limited access to sexual reproductive health services

Access to sexual reproductive health services by young people including contraception, is critical in the prevention of teenage pregnancy and other health risks. Despite this, the Service Availability and Readiness Assessment Mapping Report (SARAM, 2013) estimated that only 10% of public health facilities are youth friendly, implying that many young people in need of SRH services are unable to seek such services for fear of being judged. The KDHS (2014) further indicates that 49.3% among sexually active unmarried girls between 15-19 years and 64.2% of those aged 20-24 years use a modern method of contraceptives (mostly male

condoms). Additionally, only 2 in 5 (36.8%) currently married girls aged 15-19 years use a modern contraceptive method, while 1 in 4 (23%) of currently married girls aged 15-19 years have an unmet need for contraceptives. This means that they would like to avoid pregnancy but are not using a modern contraceptive method. There is great variation in contraceptive use among adolescents at County level as shown in Figure 10.

Figure 10. Current modern contraceptives use and unmet need for contraceptives among currently married girls aged 15-19 (%)



Source: KDHS, 2014

What is evident is that Counties with high contraceptive use tend to have lower unmet need for contraceptives than Counties with low contraceptive use (KNBS 2015). In addition, some counties with high teenage pregnancy and motherhood rates have low contraceptive prevalence rates and high unmet needs.

### f) Sexual abuse and violence

Teenage pregnancies sometimes occur in the context of human rights violations such as coerced sex or sexual abuse. The KDHS (2014) indicates that 6.5% of girls and 2.7% of boys aged 15-19 years have ever experienced sexual violence. While this signifies a decline of almost 50% from 2008/09, it remains a key issue of concern. Further, younger women and men were less likely to report violence than older women and men. For instance, 33% of girls and 20% of boys aged 15-19 years seek help to end violence, compared to 49% women and 35% men aged 40-49 years.

### g) Other factors

There are certain behavioral and cultural practices which contribute to teenage pregnancy. One such behavior is drug and substance use. The NAYS (2015) identifies drug and substance use as a key health concern among young people across all the 47 counties. Similarly, a 2012 rapid assessment of drugs and substance use in Kenya, estimated that about 18% of adolescents aged 15-17 reported ever using a drug or substance. Drugs and substances inhibit judgment and increases the likelihood of one engaging in risky sexual behavior.

Another concern that is prevalent in counties like Kilifi, and some counties in Western and Nyanza regions is “disco matangas” or “funeral discos”<sup>3</sup> These are burial ceremonies which expose young girls and boys to sexual activity, thereby increasing their vulnerability to teenage pregnancy and other health risks<sup>3</sup>.

## Recommendations

To address the challenge of teenage pregnancy and motherhood and its adverse consequences, the following key priority actions must be taken by the government and other stakeholders:

- a) **Make necessary investments to ensure that girls transition from primary to secondary school and beyond:** The government should put in place measures to ensure

that the free secondary education programme meets the education needs especially those of students from poor and disadvantaged backgrounds. Bursary programmes at national, county and constituency levels should equally be well coordinated to ensure that all needy students benefit. Efforts should equally be made to expand the free sanitary

pads programme to eliminate barriers to girl child education. Lastly, teenage girls who drop out of school due to pregnancy issues should be supported to go back to school in line with the government policy.

- b) **Make necessary investments to ensure that public health facilities are adolescent and youth friendly and that essential medical supplies including contraception, are readily available and free:** County governments should make necessary investments to ensure that public health facilities in their respective counties are youth friendly, so as to eliminate barriers that prevent young people from accessing SRH services. This will entail training of health care providers on youth friendly service provision, providing space within existing facilities for provision of adolescent and youth health services, and having in place dedicated staff to respond to the needs of young people. County governments should also ensure that essential medical supplies including contraception, both short term and long acting, are readily available and free to all sexually active young people, in all public health facilities at all levels.
- c) **Integrate relevant sexual reproductive health information into the school curriculum and other platforms (health facilities, youth empowerment centres, churches, mosques, shrines):** the education system provides the single most sustainable platform to reach young people with the right information on their sexual reproductive health. With the proposed shift by the Ministry of Education Science and Technology (MOEST) to competence based learning in the on-going curriculum reform process, knowledge on sexuality and sexual reproductive health should be considered as a key competency, taking into cognizance the contemporary social and health challenges facing learners in Kenya today. It will however be imperative that necessary investments are made to prepare teachers to deliver the information. The Department of Health at the County level should also ensure that health facilities and community health structures play a role in providing SRH information to young people. The Ministry responsible for youth affairs on the other hand should use platforms such
- as the youth empowerment centers and sporting events to deliver key messages on sexual reproductive health. Religious leaders should equally take the responsibility of empowering and mentoring young people on matters of SRH through their own platforms. There is also an urgent need to develop programmes to empower parents on how to communicate matters of sexuality with their children.
- d) **Full implementation and enforcement of relevant policies and laws:** Kenya has put in place adequate policies and laws to address the issue of teenage pregnancy and motherhood. These include: the Kenyan Constitution; the Sexual Offences Act (2006); the Children's Act (2011); the National Adolescent Sexual Reproductive Health Policy (ASRH 2015), The Education Sector Policy on HIV and AIDS (2013), the National Reproductive Health Policy; and the Population Policy for National Development. It is therefore imperative for relevant government agencies to ensure that all these policies and laws are fully enforced or implemented. Perpetrators of sexual offences and child marriages should be firmly dealt with according to the law; SRH services should be provided to all young people in need of such services in line with (Article 43 (1) of the constitution; and learners should have access to relevant sexual reproductive information as per the provisions of the Education Sector Policy on HIV and AIDS and the National ASRH Policy. The local administration and CSOs on the other hand should make necessary efforts to sensitize the public on the provisions of these policies and laws.
- e) **Initiate campaigns and community dialogues to address harmful practices:** the national and county governments should, through the relevant departments and line ministries, initiate campaigns and community dialogues to address harmful cultural practices such as child marriages, FGM and disco matangas, which drive teenage pregnancy. The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) should on the other hand initiate nationwide campaigns to discourage young people from getting involved in drugs and substance use. Lastly, CSOs should complement the government in these efforts

## References

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3. UNFPA and ICRH (2015), *Drivers of Teenage Pregnancy in Kilifi County*
4. National Council for Population and Development (2015), *National Adolescent and Youth Survey*.
5. Ministry of Youth Affairs (2011), *Youth Dialogue Tool*

