

FACTSHEET

March 2023

Adolescent Sexual and Reproductive Health in Kenya: Status and Trends

This factsheet presents Kenya's adolescent sexual and reproductive health status and trends. The main data source is the Kenya Demographic and Health Survey (KDHS). Where the data are drawn from elsewhere, we acknowledge the source of data on the specific chart and summary of the data.



Background

By 2020, over 12.7 million Kenyans were adolescents ages 10-19 years accounting for nearly one-quarter (23.7 percent) of Kenya's population (1). Kenya is experiencing a youth bulge, which is a phenomenon that occurs when more than 20 percent of a country's population is comprised of youth (children and young adults) (2). The youth bulge is caused by a reduction in infant mortality as fertility rate remains high (2). The youth bulge positions Kenya on the path to reaping the demographic dividend as the youth transition to working age individuals but only if they are fully employed in productive activities and there is an increase in the level of average income per capita. The youth bulge could also be a demographic curse if the large mass of youth are unemployed and do not earn satisfactory incomes, which could lead to social and political instability (2). To avoid this, the Kenya government must make early strategic investments to position the country to reap the demographic dividend. One necessary strategic investment is ensuring adolescents have access to education, information and services that promotes their health and wellbeing and arms them with the right knowledge and skills to thrive in the market (3). To promote the health and wellbeing of adolescents, it is crucial that they have access to education, information and services that promotes their sexual and reproductive health (SRH) to avert teenage pregnancies and sexually transmitted diseases including HIV/AIDS (3).

Kenya has made great strides in improving adolescents' SRH outcomes but many challenges persist.

Kenya's adolescent sexual and reproductive health policy environment

Kenya has ratified key international and regional policies that uphold adolescents' sexual and reproductive health and rights and also has a national policy framework for addressing these issues. In 1994, Kenya committed to implementing the International Conference on Population and Development (ICPD) Programme of Action, which placed the rights of women

and girls including their sexual and reproductive health and rights at the center of development (4). Kenya is also signatory to the 2013 Eastern and Southern Africa (ESA) commitment to scale up Comprehensive Sexuality Education (CSE) and youth-friendly Sexual Reproductive Health (SRH) services for adolescents and young people in the region (5). At the national level, Kenya's constitution provides for everyone to have a right to access reproductive health services and education (6). To steer the implementation of these global and regional commitments and Kenya's constitution, the Kenya government has a National Adolescent Sexual and Reproductive Health policy and an implementation framework (7).

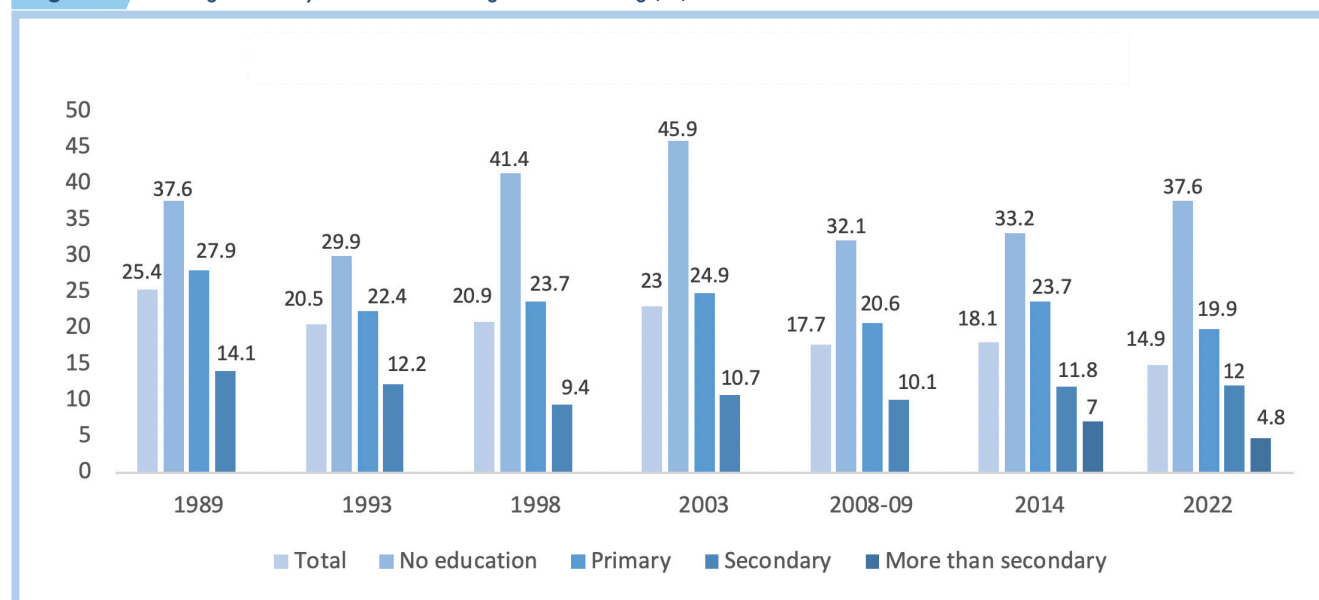
Kenya's teenage pregnancy rate has reduced but worsened among girls without education

- Teenage pregnancy has reduced but more needs to be done to support adolescent girls to stay in school to avert many more unwanted and unintended pregnancies. Figure 1 shows that there has been a gradual decline in the teenage pregnancy rate (i.e., girls ages 15-19 years who have begun childbearing) from 25.4% in 1989 to 17.7% in 2008-09 to 14.9% in 2022.
- However, the gap in the teenage pregnancy rate of adolescent girls with primary education and higher and those without education widened between the 2014 KDHS and the 2022 KDHS. In 2014, about three out of ten (29.2%) adolescent girls ages 15-19 years with no education were pregnant compared to 8.8% among those

with more than secondary education while, in 2022, it was three out of ten (30.8%) compared to 4%.

- The teenage pregnancy rate is also highest among adolescent girls from the poorest households (those in the lowest wealth quintile) and lowest among adolescent girls from the richest households (those in the highest wealth quintile).
- Eighteen (18) out of Kenya's 47 Counties have teenage pregnancy rates higher than the national level including three Counties that have rates of about 30% and over (50% in Samburu, 36.3% in West Pokot, 29.4% in Marsabit and 28.1% in Narok). Nyeri and Nyandarua Counties have the lowest teenage pregnancy rates (5% each).
- Along with the decline in the national teenage pregnancy rate, the number of births per 1000 adolescent girls ages 15-19 years was halved between 1989 and 2022, reducing from 153 to 73 in that period.

Figure 1. Girls ages 15-19 years who have begun childbearing (%)



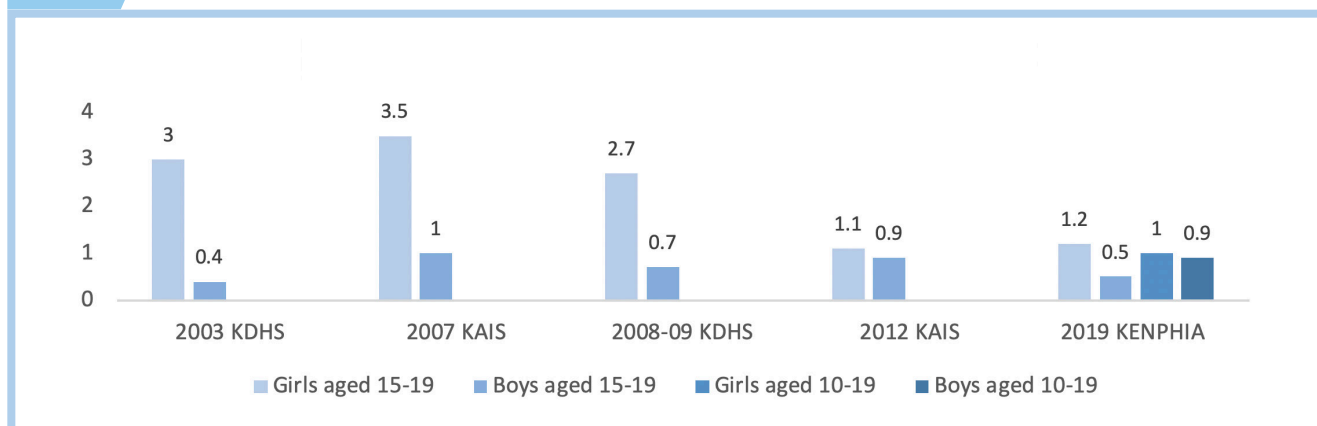
HIV has declined but girls remain at high risk

- The data used to construct the trend in adolescents HIV prevalence are from the 2003 and 2008-09 KDHSs, the 2007 and 2012 Kenya AIDS Indicator Surveys (KAIS) and 2019 Kenya Population Based HIV Impact Assessment (KENPHIA).
- HIV prevalence among adolescent girls ages 15-19 years has remained consistently higher than their male counterparts (Figure 2). The HIV prevalence among adolescent girls reduced between 2003 and 2012 from

3% to 1.1% but stagnated between 2012 and 2018 at 1.1% and 1.2%, respectively. The HIV prevalence among adolescent boys oscillated between 0.4% and 1% since 2003.

- Notably, the HIV prevalence among adolescent girls was 7.5 times higher than their male counterparts in 2003. This difference in HIV prevalence reduced considerably between 2003 and 2012 to 1.2% and then increased to 2.4% between 2012 and 2018.
- The 2019 KENPHIA also analysed the HIV prevalence among adolescents ages 10-19 years. The HIV prevalence trend among adolescent girls and boys ages 10-19 years is similar to that among adolescents ages 15-19 years (Figure 2).

Figure 2. HIV prevalence among adolescent girls and boys (%)



Self-reported sexually transmitted illnesses and symptoms is increasing among adolescent girls

- The trend in self-reported sexually transmitted illnesses (STI) and symptoms mirrors that of the HIV prevalence. A larger proportion of adolescent girls ages 15-19 years report an STI, genital discharge, or a sore or ulcer compared to their male counterparts. In addition, the proportion of adolescent girls reporting an STI, genital discharge, or a sore or ulcer increased dramatically from 3.9% in 2003 to 6.3% in 2014. Among adolescent boys the proportion reporting an STI, genital discharge, or a sore or ulcer oscillated from 2.2% in 2003, to 1.2% in 2008-09 to 2% in 2014.

- The median age at first marriage is also influenced by where adolescents live and their income status. It is lowest among adolescents from rural areas and the poorest households and highest among adolescents from urban areas and the richest households.
- In 2014, twenty (20) counties recorded a median age at first marriage among women ages 25-49 years that was higher than the national level (i.e., 20 years and over). The median age at first marriage was lowest in Migori (17.1), Tana River (17.3), Homa Bay (17.5), Wajir (18.1), and Marsabit (18.3).

Rural, poor and uneducated adolescent girls are at highest risk of early marriage

- Boys/men typically experience their first sexual intercourse earlier than girls but marry later than girls/women.
- In 1993 and 1998 (the only years KDHS reported comparative data on this), the median age at first marriage among men ages 25-49 was 24.7 years and 24.8 years, respectively, compared to 18.8 years and 19.2 years, respectively, among women ages 25-49 years.
- Over the years, the age at first marriage among women has increased from 18.1% in 1989 to 20.2% in 2014.
- Education has a strong positive effect on women's median age at first marriage. In 2014, the median age at first marriage among women ages 25-49 years was 17.9 years among those with no education, 19 years among those with primary education, 21.5 years among those with secondary education and 24.9 years among those with more than secondary education.

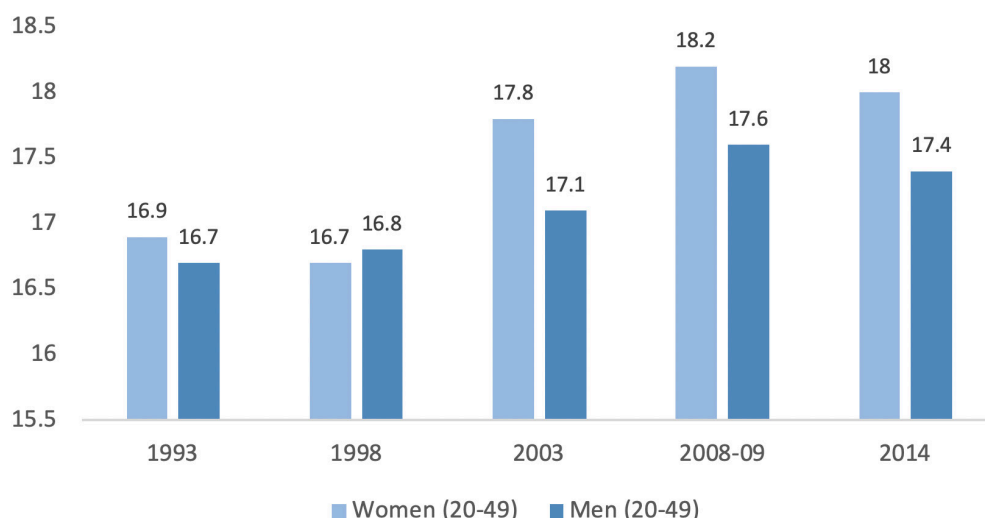
Rural, poor and uneducated adolescent girls are also at highest risk of early sexual debut

- The median age at first sexual intercourse increased from 16.9 years among women ages 20-49 years and 16.7 years among men ages 20-49 years in 1993 to 18 years and 17.4 years in 2014, respectively (Figure 3). In 2014, twenty (20) counties recorded a median age at first sexual intercourse among women ages 20-49 years that was higher than the national level. The counties with the lowest median age at first sexual intercourse were Migori (15.5), Homa Bay (15.7), Samburu (15.7), Kisumu (16.4), and Siaya (16.6).

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Figure 3. Median age at first sexual intercourse



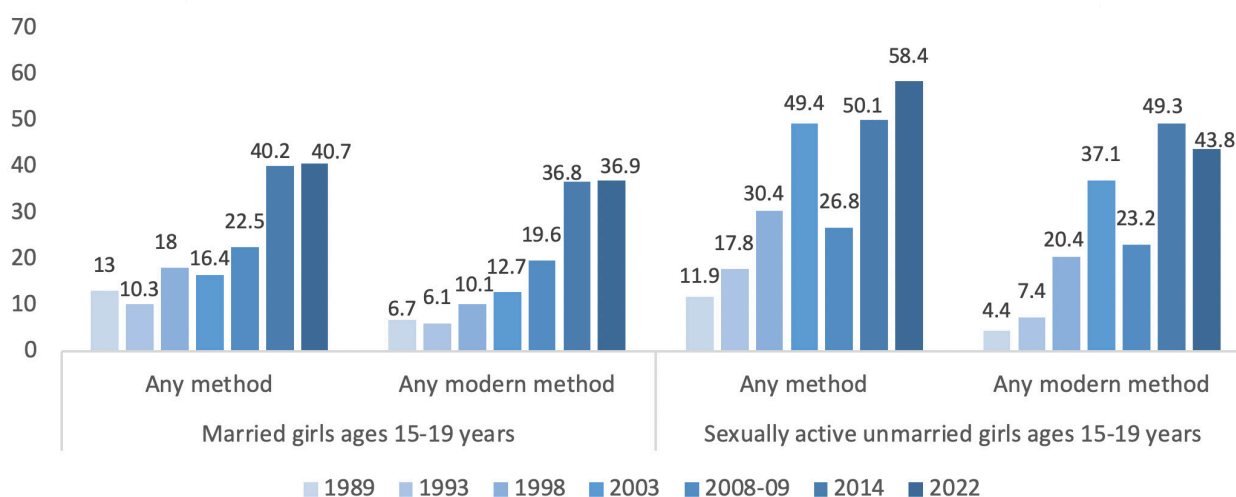
- A smaller proportion of young women and men ages 15-24 years have their first sexual intercourse by exact age 15 years than by exact age 18 years. More young men have their first sexual intercourse by exact age 15 years and exact age 18 years with their female counterparts.
- The proportion of women ages 15-24 years who had their first sexual intercourse by exact age 15 years decreased from 17.7% in 1993 to 10.4% in 2008-09 and then increased to 13.6%. The proportion of men ages 15-24 years who had their first sexual intercourse by exact age 15 years oscillated over the same period from 27.7% in 1993 upwards to 33.6% in 1998 downwards to 26.2% in 2003 and further downwards to about 22% in 2008-09 where it stagnated through to 2014.

- As is the case with age at first marriage, education has a strong positive effect on age of sexual debut and the effect is stronger among adolescent girls compared to adolescent boys.

Contraceptive use is increasing among adolescents but high unmet need among them persists

- Use of contraceptives, particularly modern contraceptives, among married and unmarried sexually active adolescent girls ages 15-19 years has increased considerably between 1989 and 2022 (Figure 4).

Figure 4. Current use of contraceptives among adolescent girls ages 15-19 (%)

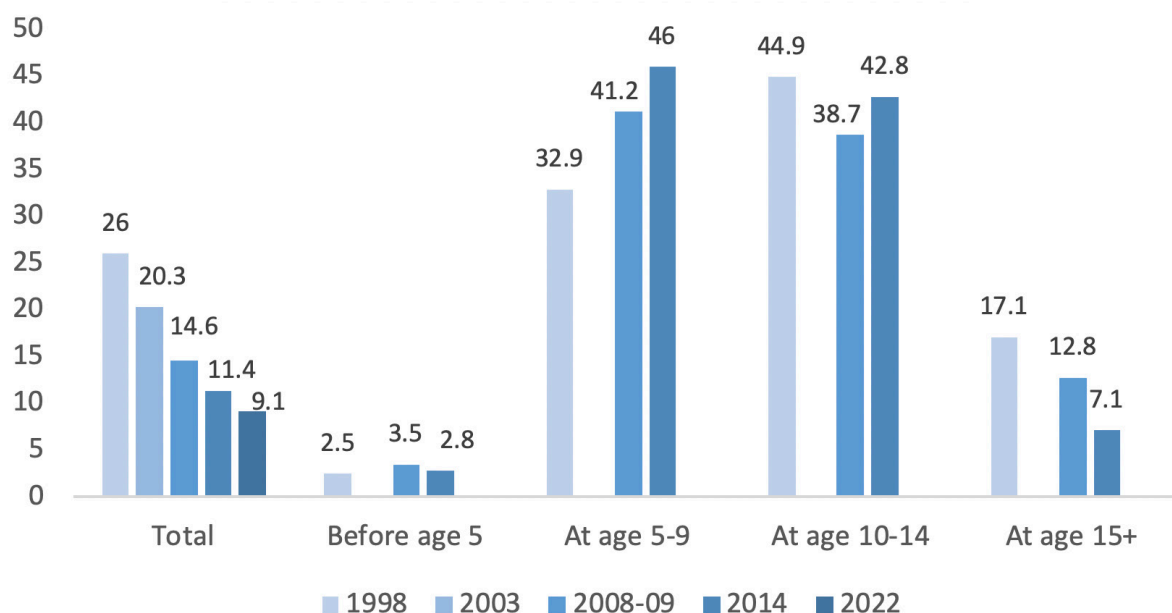


- Among the modern contraceptives used by adolescent girls, use of condoms, which is the best way to prevent the spread of STIs (including HIV) has also increased over this period among sexually active unmarried adolescent girls but remains low, and stagnated at 27.3% between 2014 and 2022.
- Condom use is uncommon among married adolescent girls and increased less rapidly compared to their unmarried counterparts between 1989 and 2022 from 0% to 3.7%. In addition, sexually active adolescent girls with more than one partners are less likely to use a condom compared to their male counterparts. In the 2022 KDHS, 1.5% of adolescent girls ages 15-19 years and 5.3% of adolescent boys ages 15-19 years reported having two or more partners. Among them, 30.7% (less than a third) of the adolescent girls and 63.5% (nearly two-thirds) of the adolescent boys reported using a condom during their last sexual intercourse.
- Notably, between 2014 and 2022, use of traditional contraceptive methods increased considerably among sexually active unmarried adolescent girls from 0.7% to 14.6%.
- Despite an increase in use of contraceptives by married and unmarried sexually active adolescents, unmet need for contraceptives (particularly modern contraceptives) remains high compared to older cohorts of women. In 2022, 21.6% of married adolescent girls and a third (34.5%) of sexually active unmarried adolescent girls had an unmet need for contraceptives compared to the national level of 14% among women ages 15-49 years.

Sexual and gender-based violence among adolescent girls persists but is decreasing

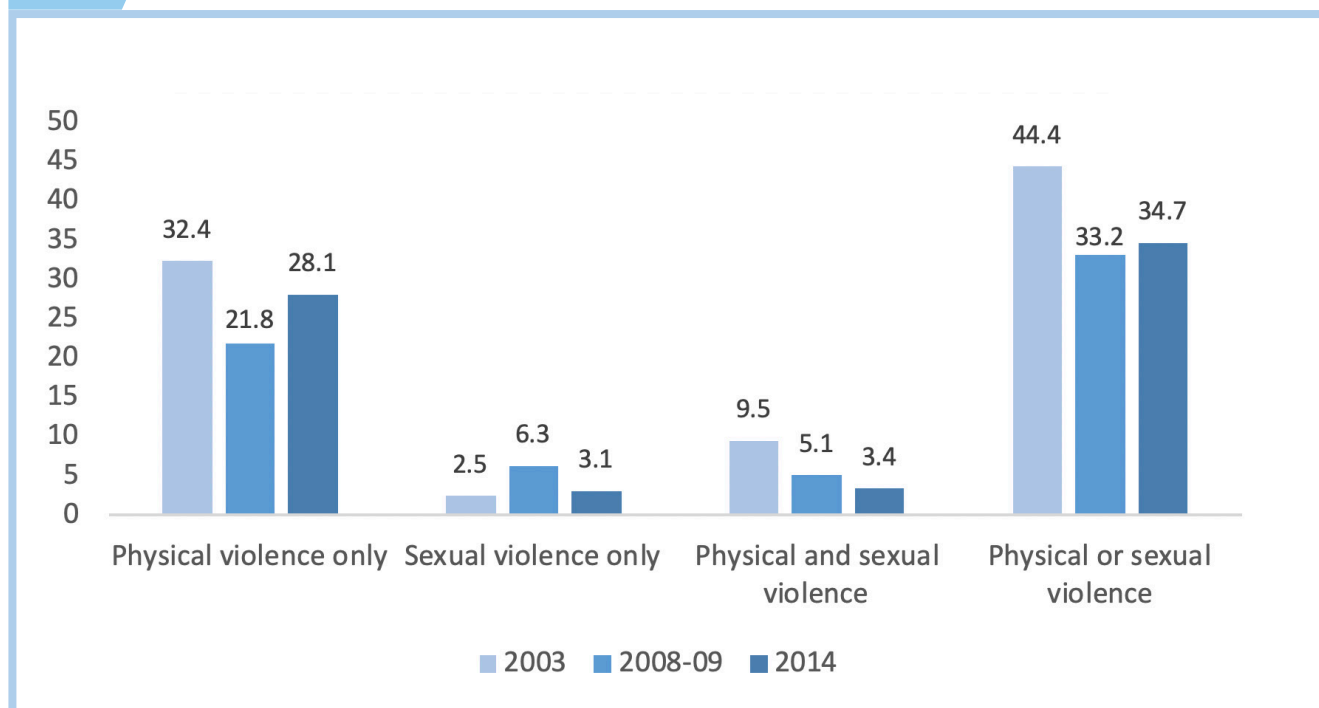
- Female genital cutting (FGC) among adolescent girls ages 15-19 years declined between 1998 and 2022 (Figure 5).
- The FGC rate is highest at ages 5-9 years and 10-14 years. The FGC rate at ages 5-9 years increased between 1998 and 2022 from 32.2% to 46% and oscillated at ages 10-14 years from 44.9% in 1998 downwards to 38.7% in 2008-09 and then upwards to 42.8% in 2014.

Figure 5. Girls ages 15-19 years circumcised (%)



- Physical violence is more commonly experienced by adolescent girls ages 15-19 years than sexual violence or a combination of physical and sexual violence (Figure 6). Physical violence among adolescent girls reduced between 2003 and 2008-09 from 32.4% to 21.8% and then increase between 2008-09 and 2014 to 28.1% while sexual violence among adolescent girls went in the opposite direction. The trend in the proportion of adolescents experiencing both physical and sexual violence was more consistent reducing between 2003 and 2014 from 9.5% to 3.4%.

Figure 6. Girls ages 15-19 years who experienced physical violence and/or sexual violence (%)



Adolescents have limited access to sexual reproductive health services

Access to sexual reproductive health services including contraception by young people is critical in the prevention of teenage pregnancy and other SRH-related risks, conditions and illnesses. 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, including adolescents, are unable to obtain SRH services that are appropriate and non-judgement.

Primary to secondary school transition has improved but continues to be sub-optimal

- Primary and secondary education have been shown to positively influence adolescent SRH outcomes, particularly of girls.

- Historically, net primary school attendance rates for both girls and boys have been much higher than net secondary school attendance rates and girls have typically outperformed boys (Figure 7). Notably, between 2008-09 and 2014, the school attendance rates for both girls and boys improved considerably (Figure 5).
- Net primary and secondary school attendance rates are lowest among adolescents from rural areas and the poorest households and highest among adolescents from urban areas and the richest households.
- In 2014, the North Eastern region was the only one that recorded a net primary school attendance rate (59.6%) that was lower than the national level. Likewise, the North Eastern region recorded a net secondary school attendance rate that was lower than the national level along with Coast (22.1%), Eastern (21.4%), Rift Valley (27.0%) and Western (24.3%) regions. Eastern (90.8%), Central (93.7%) and Nairobi (92.3%) regions had the highest net primary school attendance rates. Central (50.6%), Nyanza (38.7%) and Nairobi (51.7%) regions had the highest net secondary school attendance rates.

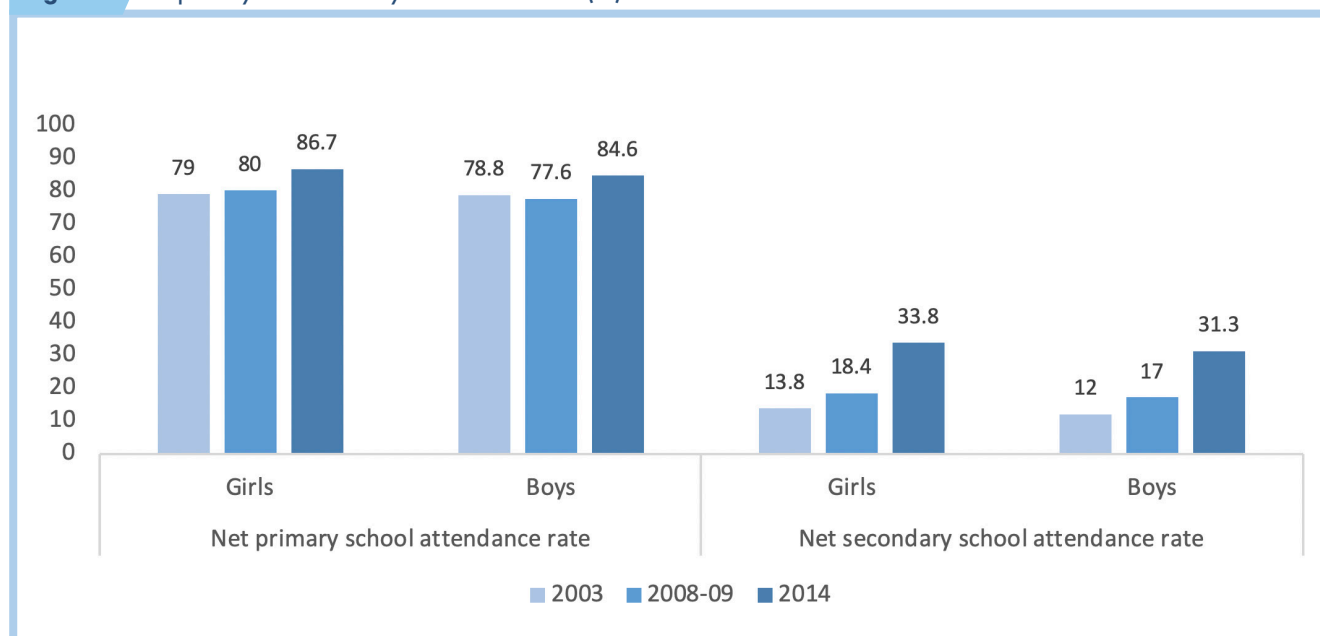
“Access to sexual reproductive health services including contraception by young people is critical in the prevention of teenage pregnancy and other SRH-related risks, conditions and illnesses.”



- Investing in getting more children, especially girls, to complete both primary and secondary school and enhancing access to CSE in and out-of-school would go

a long way toward improving adolescents' SRH outcomes and positioning them to achieve their full potential as productive members of society.

Figure 7. Net primary and secondary school attendance (%)



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