NATIONAL COUNCIL FOR POPULATION
AND DEVELOPMENT

IMPACT OF TEENAGE PREGNANCIES ON WOMEN EMPOWERMENT IN KENYA

ADVISORY PAPER NUMBER: THREE (3)

Quality Population for sustainable Development

Foreword

Empowerment of girls and women is critical for the socio-economic development of communities and nations because it enables this segment of the population to participate more fully in decision making and economic development. Since the 1994 International Conference on Population and Development various efforts at country level have been put in place to equip girls and women with knowledge and skills that broaden their choices array and enables them to make informed decisions on a wide range of issues affecting their lives with the aim of improving their wellbeing.

Teenage pregnancy has been recognized as one of the demographic events that negatively affect the future of young girls and the empowerment of women in general. Most times, teenage pregnancy means the end of schooling, beginning of motherhood in childhood, and an uncertain future for the underage mother and her child for those who survive the health risks associated with teenage pregnancies. This is a worldwide problem and various efforts, including policy and programme approaches, have been put in place to reduce and eventually eliminate it.

Kenya has made some positive strides in reducing the teenage pregnancies. In 2003, the Kenya Demographic and Health Survey estimated that 1 in every 4 teenagers aged 15-19 years have commenced motherhood. By 2014 this had reduced to 1 in every 5 teenage girls. Further reduction in this prevalence is desirable if the country is to enhance the level of women empowerment.

While the health risks associated with teenage pregnancies are well understood, the extent to which these pregnancies impact and undermine women empowerment are yet to be well understood and communicated. This advisory paper therefore assesses the extent to which teenage pregnancies negatively impact women empowerment in the spheres of education, wealth status, childcare burden, decision making on use of contraception, and experience of gender based violence. Findings of this assessment formed the basis for policy and programme advisory on teenage pregnancies given in this paper. The Council hopes that this advisory paper will prove helpful to the Country's efforts to eliminate teenage pregnancies.

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Acknowledgement

The development of this advisory paper was supported by the Government of Kenya (GoK) through the National Council for Population and Development (NCPD) as part of a series of papers aimed at providing current and sound advice on pertinent population issues that need to be addressed by both Government and stakeholders for improvement in the quality of life for Kenyans.

This advisory paper was developed by a team of officers from NCPD under the leadership of Mr. Peter Nyakwara, Director Technical Services. The Council would therefore like to thank the following four officers; Mr. Francis Kundu, Ms. Fidelis Ngung'u, Mr. Stephen Ingabo, Mr. Maurice Oduor, and Mr. Morris Gitonga for their dedication and effort in the production of this important document.

Members of NCPD Senior Management Team are also appreciated for their valuable input that went into the finalization and adoption of this advisory paper. The Council would also like to thank the external reviewers for their scrutiny that added value to the quality of this paper.

It is the hope of the Council that this advisory paper will provide valuable guidance to stakeholders who are involved in efforts to eliminate teenage pregnancies in the Country in harmony with Kenya's commitment made in November 2019 at the Nairobi Summit on ICPD25.

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Executive Summary

Teenage pregnancy, which refers to pregnancy of a female occurring between the ages of 13 to 19 years, has more than health repercussions on girls. Other repercussions of include low empowered and a bleak future for many young mothers and their newborns. This is a world-wide problem affecting millions of teenagers every year especially in low and middle income countries. The underlying drivers of teenage pregnancy in Kenya are complex and include family problems, drug and substance abuse, sexual abuse and violence, cultural practices, peer pressure, poverty, gender inequality, and lack of employment and income opportunities.

According to the Kenya Demographic and Health Survey (KDHS), the prevalence of teenage pregnancies among adolescents aged 15–19 years in Kenya was 23 percent in 2003. In 2014, this had dropped to 18 percent. Murang'a, Nyeri, Embu, and Elgeyo Marakwet Counties have the lowest prevalence at less than 10 percent while Samburu, Nyamira, Tana River, West Pokot, Homa Bay, and Narok have prevalence above the national average. Narok County has the highest prevalence in the country at 40 percent. The interventions that have been put in place to address teenage pregnancies in the country fall in the realm of legislation, policy, and programmes.

The 2014 KDHS found that women aged above 24 years and who had their first birth in their teen years had a much lower education attainment level compared to their counterparts who had their first birth after their teen years. In terms of wealth status, the results of the survey show that those with a teen birth are more likely to have a lower status compared to those who had their first birth later in life. Further, women who had a child birth while still teenagers have an average of one or two more children than those who gave birth for the first time after their teenage years. The 2014 KDHS also showed that experience of emotional, physical, and sexual violence among women who had a teenage birth and those who gave birth for the first time later in life is slightly higher among the former group. These findings reaffirm that teenage pregnancies have a negative effect on women empowerment.

ABBREVIATIONS AND ACRONYMS

GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
KDHS	Kenya Demographic and Health Survey
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
NCPD	National Council for Population and Development
UNICEF	United Nations Children Fund
WHO	World Health Organization
YFS	Youth Friendly Services
YEC	Youth Empowerment Centres

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1. Overview of Teenage Pregnancies

Teenage Pregnancy refers to pregnancy of a female occurring between the ages of 13 to 19 years. According to World Health Organization (WHO), 21 million adolescent girls aged 15 to 19 years and 2.5 million under the age of 16 years get pregnant annually across the world. Most of these girls are from low-middle income countries (WHO,2014). According to United Nations Children's Fund (UNICEF) the main rise in teen pregnancy rate is among girls younger than 15 years and close to 25 percent of these teen mothers have a second child within two years of the first birth (UNICEF, 2010). Consequences of early pregnancy can include morbidity and mortality attributable to low access to skilled antenatal, childbirth and postnatal care services as well as unsafe abortions.

Childbearing begins early in Kenya with almost one-quarter of women giving birth by age 18 and nearly half by age 20. The 2014 Kenya Demographic and Health Survey found that half of the women in Kenya aged 25 years and older who had given birth in the past did so for the first time when they were teenagers. This is also true for the same group of women in Coast, North Eastern, Eastern and Rift Valley regions. In Nairobi and Central regions, most of these women gave birth for the first time when they were past their teen years while in Western and Nyanza regions, majority had their first birth during their teen years. The proportion of women who first gave birth in their teen years was highest in Nyanza (65%) and lowest in Nairobi (37%). In urban areas, a lower proportion of this group of women (41%) had a birth during teen years compared to their rural counterparts (55%).

Teenage pregnancy has more than health repercussions on girls. It also has other negative effects including low empowered and possibly a bleak future for the young mothers and their newborns. This advisory paper explores the effect of teenage pregnancies on women empowerment in Kenya.

2. Causes of Teenage Pregnancy in Kenya

The underlying drivers of teenage pregnancy in Kenya are complex and include family problems, drug and substance abuse, sexual abuse and violence, cultural practices, peer pressure, poverty, gender inequality, and lack of employment and income opportunities. Inadequate parenting and a dysfunctional home background have been identified by experts as among key risk factors which can lead to teenage pregnancy. Studies have shown that children who have suffered parental neglect or who come from broken homes are more likely to become teenage parents. Further, those who themselves are children of teenage mothers have a higher chance of giving birth before they reach age 20.

Drugs and substance abuse is associated with increased risky sexual behaviors, early sexual

debut, risk for teenage pregnancy and exposure to HIV infection and other sexually transmitted infections, poor academic achievement, class repetition and school dropout. The Kenya National Adolescent and Youth Survey (2015) established that there are many young people, both in and out of school in each of the 47 counties, who are engaging in drug and substance abuse. According to NACADA (2016) the average age at which young persons in Kenya start engaging in drug and substance abuse is 11 years. It i also estimates that 17 percent of primary school pupils in the country are currently engaged in these practises.

Closely linked to drug and substance abuse is peer pressure. A study on factors contributing to high prevalence of teenage pregnancy in Rachuonyo district in Kenya found that peer pressure was the main contributor to teenage pregnancies. This study noted that most teenagers relied on their peers and ended up being influenced to engage in alcohol consumption and irresponsible sexual behavior (Achieng' EB, 2009).

Sexual abuse of young girls has been linked to teenage pregnancies. This may be perpetuated by a trusted person, mainly a male relative, including biological fathers and step fathers, teachers and domestic workers. A study on sexual abuse as a factor in adolescent pregnancy and child maltreatment observed that sexual victimization is contributing to the increasing rate of teenage pregnancies. The study also noted that abused adolescents were also more likely to have been hit, slapped or beaten by a partner and to have exchanged sex for money, drugs or a place to stay (Boyer, 1992).

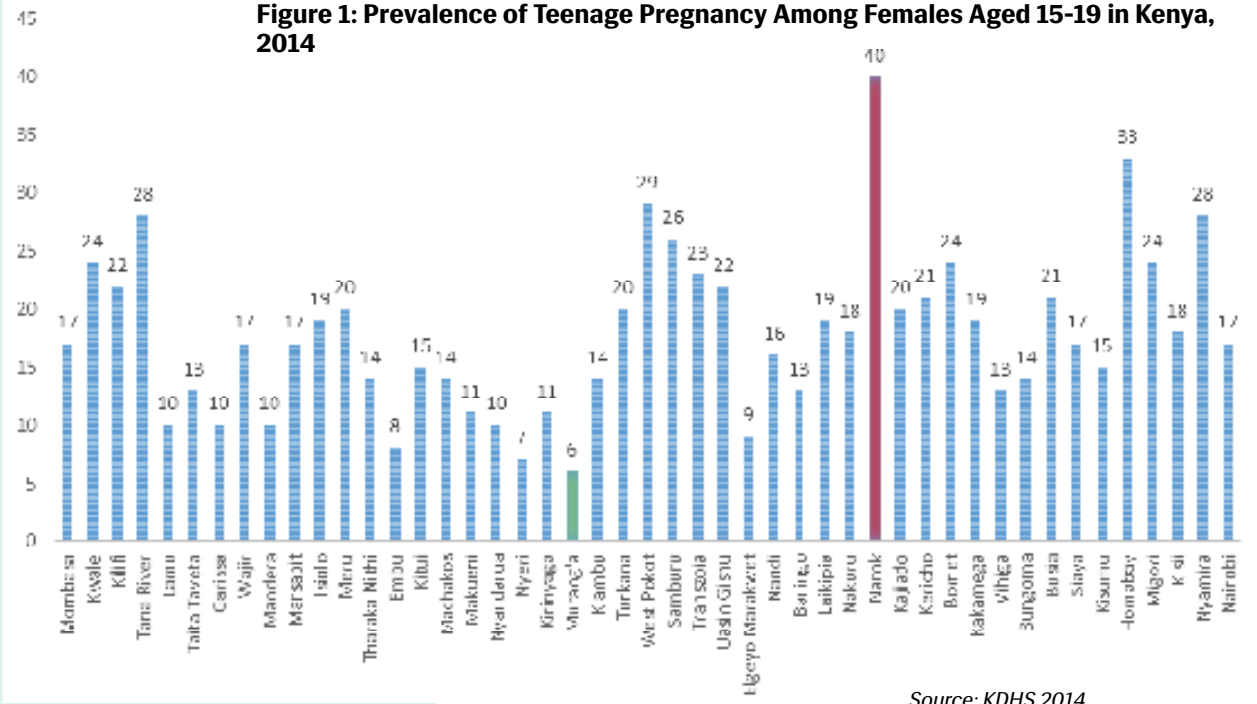
On cultural practices, one study concluded that a communication gap on matters sexuality and reproductive health exists between teenagers and their guardians (Achieng' EB, 2009). As a consequence, most young people are not taught about the changes their bodies are going through until they join school where such is taught. This gives leeway for young people to get sexuality education from peers and social media. In turn this contributes to teenage pregnancies as some of the young people experiment what they are learning from their peers and social media. In addition to this, some communities in Kenya marry off their girls as young as 10 years of age to men old enough to be their parents. At this tender age, these girls have not been exposed to any form of sexual education and have no clue on what their husbands expect from them. In the process they become major contributors to teenage pregnancies in Kenya.

Teen pregnancy is strongly linked to poverty with low income levels associated with higher teen birth rates. Due to poverty, some girls are compelled by circumstances, and in some cases by their parents, to engage in sexual activities as a source of income for the family to cater for their basic needs. In the course of this some become pregnant.

3. Prevalence of Teenage Pregnancies in Kenya

Teenage pregnancies among adolescents aged 15 – 19 years in Kenya was 23 percent in 2003 according to KDHS. Since then various efforts by Government and stakeholders were put in place to reduce this prevalence. By 2009 the prevalence had come down to 18 percent. The 2014 KDHS found that the prevalence was still at 18 percent. A look at teenage pregnancies among adolescents 15 – 19 years of age in each of the 47 counties reveals huge disparities in the prevalence rates. As shown in Figure 1, early childbearing among these adolescents is lowest in Murang'a, Nyeri, Embu, and Elgeyo Marakwet. In each of these counties, less than 10 percent of teenagers aged 15 - 19 years are mothers or pregnant with their first child. The counties with the highest prevalence rates are Samburu, Nyamira, Tana River, West Pokot, Homa Bay, and Narok where at least 1 in every 4 of these teenagers have begun childbearing. Narok County has the highest prevalence in Kenya at 40 percent, while Murang'a has the lowest at 6 percent.

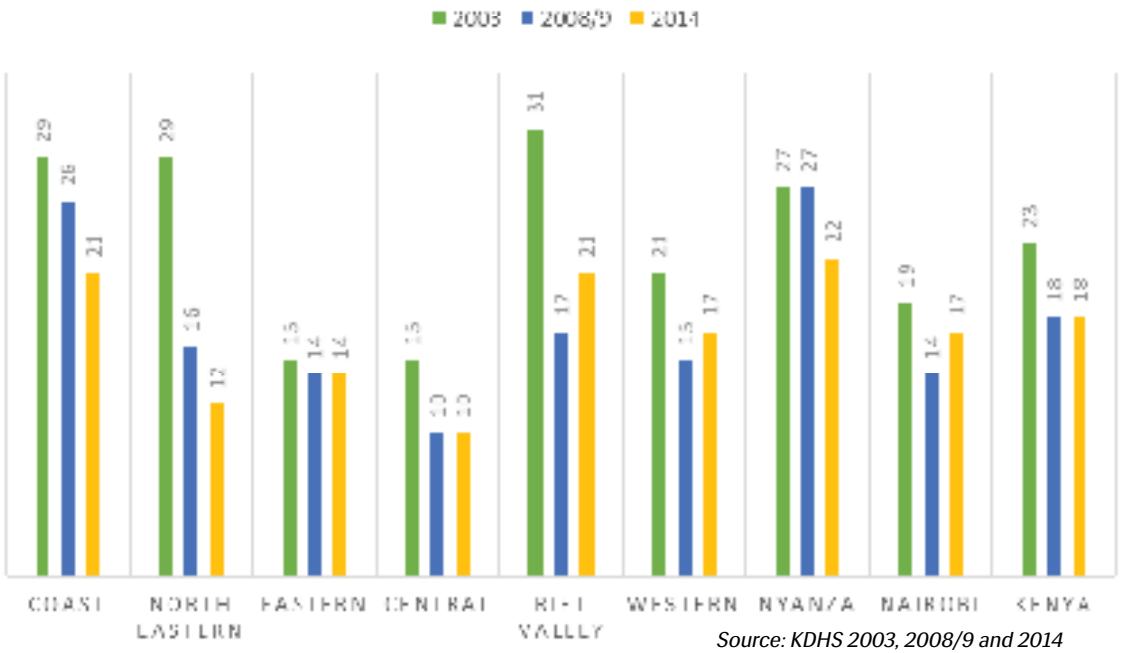
Figure 1: Prevalence of Teenage Pregnancy Among Females Aged 15-19 in Kenya, 2014



Source: KDHS 2014

At the regional level, teenage pregnancy among adolescents 15 – 19 years has generally been on the decline. The highest declines were observed in North Eastern and Rift Valley Regions between 2003 and 2014. In North Eastern region, the prevalence was reported at 29 percent in 2003 and this declined to 12 percent in 2014. In Rift Valley region, the prevalence was at 31 percent in 2003 and it declined to 17 percent in 2008/9 before increasing to 21 percent in 2014. The region that had the lowest prevalence in 2014 was Central at 10 percent while the regions with the highest prevalence are Coast and Rift Valley at 21 percent each.

Figure 2: Regional Teenage Pregnancy Trend in Kenya Among Females Aged 15-19 (2003 to 2014)



Source: KDHS 2003, 2008/9 and 2014

4. Impact of Teenage Pregnancy on Women Empowerment in Kenya

Empowerment refers to enhancing people's participation in decision making and economic development. This is achieved through awareness creation and capacity building of individu-

als. Empowering women and girls means equipping them with knowledge and skills to broaden their choices array and enabling them to make informed decisions on a wide range of issues affecting their lives. Unfortunately, the process of empowering young girls can be negatively affected if they become pregnant while in their teens.

Education attainment is a key measure of women empowerment. This is because education enables girls and women to delay marriage, manage their fertility better, participate in the labor force, and earn higher incomes. Keeping adolescents in schools has been linked to late child birth and increased women empowerment in the society. Studies have shown that there is an inverse relationship between education attainment among girls and prevalence of teenage pregnancies.

The 2014 KDHS found that women aged 25 years and more and who had their first birth in their teen years had a much lower education attainment level compared to their counterparts who had their first birth after their teen years. Among those who had a teenage birth, only 20 percent had attained secondary or higher level of education compared to 52 percent among those who had their first birth after their teen years. A look at the proportion who had attained higher education among the two groups shows a huge disparity. While 19 percent of those who gave birth for the first time after their teen years had attained higher education, less than three percent of those who gave birth as teenagers had this education attainment. The report also showed that school dropout rates at primary level was much higher among those who had a teenage birth (36%) compared to those who had their first birth later (15%).

One's wealth status has a bearing on the quality of life. Generally, those with a high wealth status tend to live better quality lives than those with a low wealth status. Various researches have concluded that low socio-economic status and poverty are associated with first childbirth during adolescence. The 2014 KDHS established that about 41 percent of women aged 25 years and more who had a birth during their teen years have a low wealth status and almost 37 percent of them have a high wealth status. For those who had their first birth after their teen years, about 26 percent have a low wealth status and 58 percent have a high wealth status. This shows that in terms of wealth as a measure of empowerment, women who had a teenage birth are more disadvantaged.

The ability of a woman to make a decision by herself or jointly with her spouse/partner on whether or not to use contraception and which type of contraceptive to use indicates the level of empowerment. The more a woman can play a role in this decision, the better their level of empowerment. According to the findings of the 2014 KDHS, about 89 percent of women who had a teenage birth are able to make the decision on contraceptive use by themselves or jointly with their spouses/partners. Among the women who had a birth after their teenage years, the same proportion are also able to make this decision alone or with their spouses/partners. In

both groups of women, only 10 percent do not participate in making this decision.

The more children a woman has the more time and resources she needs to spend providing childcare. This can negatively impact on a woman's ability to acquire more education, participate in the labor force and acquire higher income for her household. An analysis of the 2014 data on women aged 25 years and older who had a birth in the past shows that those who had a child birth while still teenagers have an average of one or two more children than those who gave birth for the first time after their teenage years. The same is true for the same group of women in each of the following cohorts; 25-29, 30-34, 35-39, 40-44, and 45-49 years. This shows that those who became mothers in their teens carry a heavier childcare burden than those who became mothers later.

Violence, in any form, perpetuated against women is unacceptable. Programmes to empower women against these vices have therefore been put in place to minimize such incidents. Legislation has also been enacted to punish perpetrators. The 2014 KDHS showed that experience of violence, in any of its forms, among women who had a teenage birth and those who gave birth later is slightly higher among the former group. The type of violence experienced most by both groups of women are; less severe physical violence, emotional violence, severe physical violence, and sexual violence in that order. About 15 percent of women who had a teenage birth experienced sexual violence compared to 12 percent of those who had a birth later in life.

5. Interventions to Address Teenage Pregnancies in Kenya

The interventions that have been put in place to address teenage pregnancies in the country fall in the realm of legislation, policy, and programmes. Legislations that are in place include those that prohibit gender based violence and sexual relations with children. Other legislation in place, which contribute to curbing the problem of teenage pregnancies, are those that outlaw cultural practices such as female genital mutilation and child marriage. These legislations are the Children Act (2002), Sexual Offences Act (2006), Prohibition of Female Genital Mutilation Act (2011), and the Constitution of Kenya (2010).

On the policy front, the Ministry of Education is implementing a return to school policy which allows girls to return to school and continue with their education after childbirth. Another policy is the National Adolescent Sexual and Reproductive Health Policy which is being implemented by the Ministry of Health. This policy supports the provision of Youth Friendly Services (YFS) to young persons with the aim of empowering and facilitating them to make the right choices pertaining to their sexuality. The Kenya Youth Development Policy was developed by the State Department of Youth in 2018. It seeks to improve the social and econom-

ic wellbeing of youth in the country by, among other things, removing obstacles that impede their participation in social and economic activities. Setting up of Youth Empowerment Centres (YEC) in the country is provided for in this policy.

In addition to the above, various Government and non-government institutions, including Civil Society Organizations (CSOs), are implementing programmes and projects that directly or indirectly address issues of teenage pregnancies in almost all parts of the country. This includes mainstreaming the ASRH policy in County plans, advocating for adolescent and sexual reproductive health issues, upscaling guidance and counselling services in schools, provision of sanitary towel to girls both in and out of schools. In addition, some of organizations have set up safe houses and gender based violence rescue centres to help girls who are risk of undergoing FGM, becoming child brides, and experiencing gender based violence. These efforts have significantly contributed to decreasing the prevalence of teenage pregnancies in Kenya over the years.

6. How can we further reduce teenage pregnancies in Kenya?

Teenage pregnancies are a matter of grave concern to Kenya given that it works against the wellbeing of girls and women. Evidence shows that girls who give birth during their teenage years are disadvantaged later in life in terms of education attainment, wealth status, childcare burden, and to a smaller extent experience of various forms of violence. This implies that they are generally less empowered compared to their counterparts who gave birth after their teen years. In turn, this has a negative effect on the development efforts of the country which requires the effective participation of all men and women. To further reduce the prevalence of teenage pregnancies, the following recommendations are made;

- Implement, through the Ministry of Health, the Government Commitment No. 1 made at the Nairobi Summit on ICPD25. Under this commitment, Kenya affirmed that it would employ innovation and technology between 2020 and 2030 to ensure that adolescents and youth attain the highest possible standard of health. This commitment entails, among other things, activities aimed at eliminating teenage pregnancies.
- Further efforts be made through the Ministry of Education and relevant stakeholder to ensure that all school going age children who have never attended school and those who have dropped out of school are taken to school with the aim of enabling them to at least complete primary school and acquire some skills training.
- The Government, with support from stakeholders, to provide the State Department for Gender, National Gender and Equality Commission, and the Anti-Female Genital Mu-

tilation Board with all the human, technical and financial resources required to end female genital mutilation by 2022 and both child marriages and sexual and gender based violence by 2030 in line with the Government Commitment Nos. 13, 14 and 15 made at the Nairobi Summit on ICPD25.

Implementation of the above recommendations will require the full involvement of all stakeholders including civil society organizations and communities in all parts of the country. The successful implementation of these recommendations will improve the level of women empowerment in the country and contribute to national development aspirations.

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