Forum for African Women Educationalists Kenya

FAWE Forum for African Women Educationalists
Forum des éducatrices africaines

In partnership with
mastercard foundation

SITUATIONAL ANALYSIS REPORT ON TEEN PREGNANCIES IN KENYA

FOREWARD FROM PRINCIPAL SECRETARY, MINISTRY OF EDUCATION

It is an honor to present during the launch of the "Imarisha Msichana: Teen Pregnancies During and Post COVID-19" situational analysis report, which provides a comprehensive examination of one of the most pressing challenges facing our nation today. This report is a significant contribution to our collective efforts to address and reduce teenage pregnancies, a challenge that has been exacerbated by both natural and man-made crisis as the COVID-19 pandemic, floods and even droughts across 20 counties in Kenya.

These crises have disrupted every aspect of life, with profound impact on education and adolescent health. The closure of schools, the economic hardships faced by families, and the limited access to reproductive health services have created an environment where our teenage girls are increasingly vulnerable. This report shines a light on the stark realities faced by teenage girls during this challenging period and provides us with critical insights that must guide our actions moving forward.

Education is a powerful tool in the fight against teenage pregnancies. It is not only a fundamental right but also a means to empower our girls, enabling them to make informed decisions about their health and futures. The Ministry of Education, in collaboration with our partners notably FAWE, is committed to ensuring that every girl in Kenya has access to quality education in a safe and supportive environment.

The findings of this report highlight the urgent need for a coordinated and multi-sectoral response. No single entity can address this challenge alone. We must work together government agencies, non-governmental organizations, community leaders, educators, healthcare providers, and families to create a supportive network for our girls. We must ensure that they have the knowledge, resources, and opportunities to avoid early pregnancies and to pursue their dreams.

The recommendations provided in this report offer a roadmap for our action. They call for strengthened policies, enhanced community engagement, improved access to reproductive health services, and the provision of safe spaces for girls. These are not just recommendations; they are calls to action that demand our immediate attention and commitment.

As we launch this report, I call upon all stakeholders to join hands in implementing these recommendations. Let us work together to create an environment where every girl can grow up free from the fear of early pregnancy and child marriage but where she can complete her education and contribute meaningfully to the development of our nation.

I would like to express my deep appreciation to FAWE in partnership with Mastercard Foundation in the development of this report. Your dedication to the welfare of our girls is commendable, and your work will have a lasting impact on the future of our country.

Thank You

Dr. Belio Kipsang’

PS, MINISTRY OF EDUCATION- KENYA.

FORWARD FROM THE CEO, FAWE KENYA CHAPTER

Dear Stakeholders,

Natural and man-made crisis like pandemics as the COVID 19, the droughts and Floods we have experienced as a country introduce unprecedented challenges across all sectors, with its impact being severe on vulnerable populations, including teenage girls. The "Imarisha Msichana" program was launched with the aim of addressing the alarming increase in teenage pregnancies during and after the COVID-19 pandemic. This situational analysis report is a critical component of our ongoing efforts to understand the underlying factors contributing to the rise of teen pregnancies post crisis as floods, drought and even health crisis as the COVID 19.

Through this report, we seek to illuminate the multifaceted challenges faced by teenage girls and provide actionable insights. The findings drawn from extensive research, including interviews, surveys, and data analysis, reflect the voices and experiences of those directly impacted. Therefore, the insights presented in this report are not just statistics; but reflect the lived experiences of teenage girls, their families, and communities.

As stakeholders committed to improving the health, education, and well-being of our girls, it is incumbent upon us to translate these findings into actionable strategies that can drive meaningful change. The report provides an opportunity to develop targeted interventions to mitigate these issues.

While thanking the partnership between FAWE and Mastercard Foundation in support of girls' empowerment through education, I urge all stakeholders, government agencies, Partners, community leaders, educators, and NGOs to consider the recommendations within this report as we collaborate to build a safer, healthier, and more supportive environment for our teenage girls. Together, we can ensure that no girl is left behind. It is time to have the girls' voices in our policy documents.

Thank you for your continued dedication to this critical cause.

Sincerely,

Jeannette Nyanjom

CEO, FAWE Kenya Chapter

ACKNOWLEDGEMENTS

The successful completion of this situational analysis report on teen pregnancies in 20 counties in Kenya was made possible through the collaboration and support of individuals and organizations.

First and foremost, we are thankful to our partners, Mastercard Foundation whose financial and technical support significantly contributed to the successful execution of this study. Their commitment to protecting and empowering adolescent girls remains an inspiration to all of us.

We acknowledge the vital role played by the institutions and individuals in the 20 counties included in the analysis that provided support during the conduct of the Situational survey. Their collaboration and provision of local data were crucial in ensuring the accuracy and relevance of our findings.

A special thank you to the consulting firm, Seamays International Research, led by Nashon Kaloki Ng'elu, and the editor, Marambo Elijah Otiende, whose expertise and dedication were pivotal in conducting a thorough and insightful analysis. We also appreciate the hard work of the field researchers, data analysts, and County Coordinators, who overcame numerous challenges to ensure the successful completion of this report.

Our gratitude extends to the validation stakeholders who were drawn from different entities including MoE, KICD, TSC, KRCS, CREAW, Strathmore University, and independent researchers among others for their valuable input to the report. Their ongoing work in the field is a testament to their commitment to safeguarding the rights and well-being of teenage girls.

Finally, we appreciate the support of FAWE team for facilitating the successful completion of the exercise. The efforts behind the scenes ensured the smooth execution of this programme.

This report is a product of shared commitment, collaboration, and a deep-seated belief in the potential of every girl to thrive. We hope it will serve as a valuable resource for driving change and fostering a more equitable and supportive environment for teenage girls in Kenya.

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LIST OF ABBREVIATIONS AND ACRONYMS

ASAL	Arid and Semi-Arid Lands
ASRH	Adolescent Sexual and Reproductive Health
AU	African Union
AYSRHR	Adolescent and Youth Sexual and Reproductive Health Rights
CBO	Community-Based Organization
CHW	Community Health Workers
CM	Child Marriage
COVID-19	Corona Virus 2019
CREAW	Centre for Rights Education and Awareness
CRPD	Convention on Rights of Persons with Disability (by United Nations)
FAWE RS	Forum for African Women Educationalists Regional Secretariat
FAWEK	Forum of Africa Women Educationalists Kenya
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GPS	Global Positioning System
KCPE	Kenya Certificate of Primary Education
KCSE	Kenya Secondary Certificate of Education
KDHS	Kenya Demographic Health Survey
KHIS	Kenya Health Information Management System
KNH	Kenyatta National Hospital
KRCS	Kenya Red Cross Society
MCH	Maternal and Child Health Care
MoE	Ministry of Education
MoH	Ministry of Health
MoPHS	Ministry of Public Health and Sanitation
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
NGOs	Non-Governmental Organization
PWDs	Persons with Disabilities
SGBV	Sexual and Gender-Based Violence
SPSS	Statistical Packages for Social Sciences
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Diseases
TP	Teenage Pregnancies
TSC	Teachers Service Commission

UNCRC	UN Convention on the Rights of the Child
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

OPERATIONAL DEFINITIONS OF TERMS

Boyfriend:	A person of male gender with whom the school-going girls had a romantic relationship with, whether of the same age or not. In this study, the respondents noted boyfriend to mean, classmates, school mates, male friends from other schools or in colleges, and in some cases, male friends not schooling.
Child marriage:	According to UNICEF, child marriage refers to any formal marriage or informal union between a child under the age of 18 and an adult or another child.
Child protection:	This implies policies, measures, and activities that enhance the protection of children from abuse and any other form of harm.
Family-life	A term that refers to a combination of social approaches, including training on communication skills with peers, knowledge on typical human development, healthy inter-personal relationships, life skills, positive self-esteem, and good decision-making,
Sexual debut:	Also termed as early sexual initiation. it is the age at which a person has sexual intercourse for the first time in their lifetime.
Teenage births:	These are births that occur among girls in the teenage brackets, from 13 to 19 years old.
Teenage Pregnancy:	This refers to the pregnancy that occurs amongst of women aged below 19 years who have ever been pregnant.
Teenage women:	These are girls/women who are within the teenage bracket of 13 to 19 years.
Unintended pregnancy:	This refers to a pregnancy that occurs with no prior plan. It is mistimed, and unplanned at the time of conception.

EXECUTIVE SUMMARY

Introduction

The onset of the coronavirus (COVID-19) led to a disruption of normalcy across all sectors. Education was among the most affected sectors leading to school closures and unprecedented long holiday periods. Studies have shown that during this period of long school closures meant to slow down the spread of COVID-19, many young school-going girls got pregnant, others were married, and others dropped out of school. The cases of teenage pregnancies in Kenya rose steadily, creating a debate on what could be done to reduce the prevalence. In addition to the COVID-19, Kenya has also experienced prolonged droughts (in 2022) as well as recurrent floods in 2023 and 2024 which further disrupted schooling. Similarly, drought which has been perennial in the Arid and Semi-Arid areas (ASALS) counties of Northern Kenya and South Rift has disproportionally affected girls' schooling, exposing them to teenage pregnancies and marriages. While the natural causes have the highest impact on learning, man-made causes like teachers strikes, political demonstrations especially during electioneering year 2022 and those during the reading of fiscal budgets have similarly caused disruption in learning, leading to prolonged stay at home for learners. According to the UNFPA Report (2021) on "Ending FGM and child marriages in Kenya," it was observed that over 125 million girls and women face FGM in Africa and the Middle East, a practice that exposes them to child marriages as their communities perceive them as "mature for marriage." Child marriage is strongly linked to teenage pregnancy, where one directly leads to the other. Studies have also shown that child marriage and teenage pregnancies are strongly linked to other health issues like maternal deaths and injuries for girls during pregnancy and childbirth, premature births, obstetric fistula, sexually transmitted diseases and domestic violence. Similarly, there are some pre-disposing factors to teenage pregnancies, like the type of residence, where teenage girls from informal settlements and in deep rural areas are more exposed compared those from urban and affluent backgrounds.

The study primarily aimed to gain an understanding of the status of teenage pregnancy and Child Marriage in the Country, with a special focus on target countries ahead of program implementation. In implementing the study, the following were the key focus: (b)teenage pregnancies in Kenya, (c) Girls at risk of teenage pregnancy, and (d) the Magnitude of teenage pregnancy in selected 20 counties.[1] (e) factors leading to teenage pregnancies, (f) Effects of teenage pregnancies on girls, (g) Various national laws and policies and by-laws on handling teenage pregnancies in Kenya, and finally, (h) Best practices in reducing girls' exposure to teenage pregnancies and child marriages.

Methodology

This situational survey adopted a consultative and participatory approach involving a mixed-method and cross-sectional analytic study design. The study used a combination of both quantitative and qualitative methods of inquiry to facilitate data generation, analysis, and triangulation. The survey sample size was 1,030 teenage and young girls and boys, spread out in twenty counties in Kenya. Data quality checks and ethical principles were adhered to during data collection. Quantitative data analysis was done using Excel, SPSS, and STATA, while qualitative data was processed through content and thematic analysis. Emerging themes were supported with quotes and verbatim from the participants. Information was presented through data tables, charts and graphs for the quantitative data, and verbatim and case studies for the qualitative data.

[1] Bungoma, Busia, Elgeyo Marakwet, Garissa, Homabay, Kajiado, Kakamega, Kiambu, Machakos, Meru, Migori, Muranga, Nairobi, Nakuru, Narok, Nyandarua, Nyeri, Siaya, Trans Nzoia and Turkana

Findings and discussion

In this situational analysis done in late 2022 and early 2023, 1,030 participants were interviewed. A significant number of the study participants, 42%, were those aged 18-25 years, those between 15 -18 years formed 36%, and those aged below 14 years were 22%. The findings established 19.9% teenage pregnancy rates in twenty counties during the 2020-21 period, at the peak of COVID-19. The twenty counties had significantly higher teenage pregnancy rates than the national average of 15%, as reported by the Kenya Demographic Health Survey (2022). The situational analysis further established that teenage pregnancy was **prevalent among girls aged 15-18** years at 27.4%, followed by 19-25 years (23.7%). The counties with the highest prevalence rates were Narok (43.3%), Kajiado (35.6%), and Turkana (34.2%), while the counties with the lowest teenage pregnancy rates were Nyeri (6%), Nyandarua (8%), and Murang'a (9.2%).

According to this report, child marriage was prominent in Garissa at 43%, with Turkana coming second at 38%, Nairobi (22%), and Meru (14%). The report further established that 18.6% of those aged between 15-18 were in child marriages, signifying a reduction from 23% (KDHS:2014). On the contrary, only 3% of boys in Kenya were married before the age of 18 years.

The study established that out-of-school girls, refugee girls, Asylum seekers, absentees, girls from specific geographical areas (poor rural, poor urban, and ASAL), and girls with disabilities were at risk of teenage pregnancy compared to other girls of the same age group despite the relevant laws and policies, including strategies such as age-appropriate family health Education, Youth Friendly Service, and Youth clubs/Tuseme implemented in schools, communities, and government health centers. Factors leading to teenage pregnancy and child marriage remained drug and substance abuse, poverty, gender-based violence, child marriage, culture and traditions, lack of SRH information and services, lack of parental supervision, social media influence, and early sexual debut.

Overall, different practices are in place, ranging from Comprehensive Sexuality Education to the Provision of Adolescent Youth-Friendly Services, Engagement of boys in pregnancy prevention, Law and policy enforcement, promotion of school club activities, and provision of Menstrual Hygiene products, which has been put in place by communities, parents, CSOs, and the government to reduce girls' exposure to teenage pregnancies and child marriages.

Conclusions

In conclusion, cases of teenage pregnancies and child marriages remain high in Kenya, and specific counties, continue to battle the ever-rising cases of teenage pregnancies. The COVID-19 pandemic, along with other crises like the prolonged drought in 2022, floods in late 2023 and 2024 further spiked teenage pregnancies despite relevant laws, policies, and strategies in schools and communities. The five factors associated with teenage pregnancies are Early Sexual debut, social media influence, lack of parental supervision, Inadequate access to family life information, Inadequate access to education and Culture and tradition are closely interlinked, and a comprehensive approach to reducing and eliminating is likely to be the most effective.

Teenage pregnancy is a major challenge that deprives schoolgirls of the opportunity to further their education and attain their career goals. It further exposes young girls and their children to major health risks, leading causes of death, mental health problems such as depression, poor performance in school, and social problems such as stigma and discrimination.

Kenya has several best practices for addressing teenage pregnancies, along with commendable legal guidelines and policies. This confirms that there is undoubtedly a resolve to address the existing negative ASRH indicators and provide an enabling environment.

Recommendations

The following are the recommendations from the situational analysis on teenage pregnancies and child marriage.

1. Increase Awareness of National Guidelines: The Ministry of Education (MoE) should enhance awareness of the National Guidelines for School Re-Entry in Early Learning and Basic Education 2020. This can be achieved through targeted campaigns and informational sessions for educators, parents, and students. It can be done as a collaborative endeavor involving all education stakeholders, including MoE, KICD, and organizations such as FAWE-K, FAWE-RS, KRCS, and CREAW, among others.
2. Promote Parental Education: The MoE, other partners and religious leaders should prioritize parental education programs to ensure parents are well-informed about the importance of school re-entry policies and the role they play in their children's education.
3. Expand Family-Life Counselling: The MoE, other partners and religious leaders should implement and expand family-life counselling services within schools to support students and families in navigating challenges related to school re-entry and overall well-being.
4. Enhance School Mental Health Initiatives: The MoE, MoH, other partners and religious leaders should strengthen mental health support in schools by integrating comprehensive mental health programs that address the emotional and psychological needs of students, particularly those re-entering the education system
5. Harmonize Law and Policy Enforcement and Provide Financial Assistance: The Ministry of Education and other partners should ensure coordinated support for the enforcement of laws and policies at all levels, while also providing financial assistance to needy girls and boys to enable them to access and complete basic education.
6. Strengthen Partnerships and Enforce Laws: The Ministry of Education (MoE) and other partners should enhance its collaboration with NGOs and relevant agencies to implement programs that raise awareness of laws and policies in schools and communities. Additionally, it is essential to rigorously enforce laws and policies aimed at eliminating teenage pregnancy and child marriage, with a particular focus on holding perpetrators accountable at all levels.
7. Establish Adolescent-Friendly Services and Sensitization Campaigns: The Ministry of Education, in collaboration with partners such as FAWE-K, should establish adolescent youth-friendly services, conduct sensitization campaigns, and create clubs in schools. These initiatives should be implemented as best practices to reduce girls' exposure to teenage pregnancies and child marriages.

SECTION ONE: BACKGROUND OF THE STUDY

1.1 Background of the Project

The "Imarisha Msichana Project" seeks to empower teenagers and young girls to achieve their life goals by reducing the prevalence and incidences of teenage pregnancies and child marriage. The Imarisha Msichana Project, ***Her Education Her Future***, is a partnership between the Forum for African Women Educationalists (FAWE) and Mastercard Foundation. The project was initiated based on the vulnerabilities of school-going girls exposed by the advent of COVID-19. The program targets adolescent girls (9-17) and young women (18-25) who have fallen through the cracks of education because of teen pregnancy and those that are at risk of the same. The ***Her Education Her Future*** seeks to reduce cases of Teenage Pregnancy [TP] and Child Marriage [CM] in Kenya.

The cases of teenage pregnancies and child marriages in Kenya have risen steadily, creating a debate on what should be done to reduce the prevalence. According to the UNFPA Report (2021) on "Ending FGM and child marriages in Kenya," it is observed that over 125 million girls and women face FGM in Africa and in the Middle East, a practice that exposes them to child marriages after graduating to "mature for marriage."[2] The UNFPA reports note that if the current trends are not addressed to end child marriage, then the number of under 15 girls giving birth is expected to increase from 2 to 3 million by 2030. Similarly, the report asserts that if no action is taken, then by 2030, over 14 million girls below the age of 18 years will have been married annually. Child marriage is strongly linked to teenage pregnancy, where one directly leads to the other.[3]

Studies have shown that child marriage and teenage pregnancies are strongly linked to other health issues like maternal deaths and injuries for girls during pregnancy and childbirth, premature births, domestic violence, obstetric fistula, and sexually transmitted diseases. The comorbidities associated with child marriage and teenage pregnancies call for urgent action to reduce the associated health and social burden. Investing in the reduction of TP and CM among young girls will lead to better health outcomes, better education opportunities, and a better-quality life.

Narrowing to the Kenyan setting, a report by Iris Group (2020) indicates that the rates of child marriage (particularly under-15 marriage) have minimally reduced in Kenya. Based on the 2014 KDHS, 22.9% of women and 2.5% of men aged 20-24 were married before age 18, while 4.4% of women and 0.3% of men in the same age group were married before age 15.[4] While the data showed a high prevalence of TP and CM, recent studies and government data (Kenya census 2019 and KDHS 2022-23) have not provided the latest statistics on the social problem of teenage pregnancies and child marriages.

Based on the above findings and the advent of COVID-19, teenagers and young women have faced challenges, including the likelihood of TP and CM. This situational analysis sought to provide key and critical information on how the program can use data to monitor the progress of reducing teenage pregnancy and early marriage. This survey sought to establish the status and influence of COVID-19 on teenage pregnancy and child marriage in Kenya, narrowing it to select 20 counties in Kenya. The findings will help in guiding the re-structuring of sustainable and impactful interventions.

Project context and aim: The study's scope was to establish the status of teen pregnancy and Child Marriage post COVID-19 with a focus on 20 Counties.

[2] https://kenya.unfpa.org/en/publications/ending-fgm-and-child-marriage
[3] https://www.kit.nl/wp-content/uploads/2018/10/Baseline-report-Kenya-Yes-I-Do.pdf
[4] https://www.girlsnotbrides.org/documents/1626/Kenya_Mini_PEA_Final_Doc.pdf

Study Objective: The study's purpose was primarily to understand the status of teenage pregnancy and Child Marriage in Kenya, focusing on 20 counties [Bungoma, Busia, Elgeyo Marakwet, Garissa, Homa-Bay, Kajiado, Kakamega, Kiambu, Machakos, Meru, Migori, Murang'a, Nairobi, Nakuru, Narok, Nyandarua, Nyeri, Siaya, Trans-Nzoia, and Turkana]. In implementing the study, the following were the key objectives:

1. To establish the number of impregnated girls and child marriages in 20 counties.
2. To document factors contributing to TP/CM in the target counties
3. To document the effects of TP/CM on girls in the counties of focus
4. Identify and analyze various national laws and policies, ordinances and by-laws, and necessary protocols on TP/CM
5. To document good practices in reducing girls' exposure to TP/CM and propose an effective model for addressing teenage pregnancies in Kenya

2.0 SECTION TWO: METHODOLOGY

2.1 Study Design

The purpose of the study was primarily to gain an understanding of the status of teenage pregnancy and Child Marriage in the Country, with a special focus on target countries ahead of program implementation.

The study used a cross-sectional descriptive research design, embracing both qualitative and quantitative data collection and analysis methods. Related information on teenage pregnancy and child marriage was reviewed and triangulated with data from multiple sources to enhance the accuracy and validity of study findings. The following diagram summarizes the research approach used in the study.

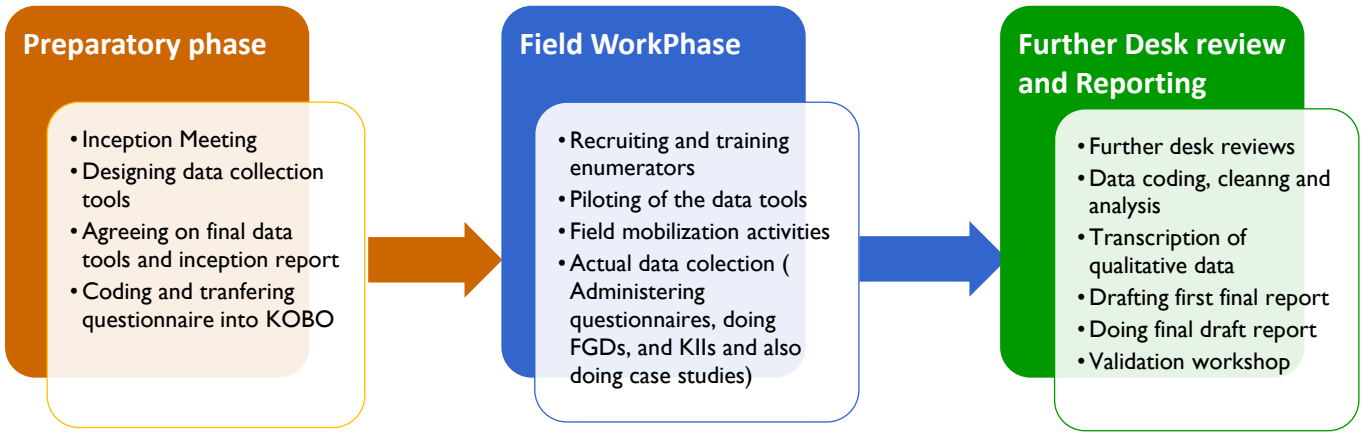


Figure 1: Summary of research design

2.2 Geographical Scope

The study covered 20 counties in Kenya as shown in Table 1. FAWEK conceptualized that the selected counties had seen a spike in teenage pregnancies, as reported during the COVID-19 period in Kenya (2020-2022).[5] The 20 counties were also selected because they are FAWEK program areas and had high teenage pregnancy rates.

Table 1: Geographical focus of the survey

Nairobi, Eastern & Others	Central region	Rift Valley	Western & Nyanza
• Nairobi • Machakos • Meru • Garissa • Kajiado	• Muranga • Nyandarua • Kiambu • Nyeri	• Nakuru • Narok • Trans-Nzoia • Turkana • Elgeyo Marakwet	• Migori • Bungoma • Busia • Homa-Bay • Kakamega • Siaya

[5] Ibid.

2.3 The Study Target Population

The target population for the quantitative method were girls and young women aged between 9 to 25 years in the 20 select counties in Kenya. The target was based on population exposure to factors leading to teenage pregnancies, child marriage, and the likelihood of the group experiencing adverse effects associated with teenage pregnancies. Similarly, the inclusion of girls up to 25 years was due to the possibility of over-age that characterizes learners, especially in the arid and semi-arid counties of Turkana, Narok, Kajiado, and Elgeyo Marakwet. Focus group discussants were drawn from the community members, teenage girls, teenage mothers, and young boys. Case studies were also done for girls who had experienced teenage pregnancy or child marriage. The case studies targeted teenage girls who had experienced pregnancies while in school. The idea was to understand how teenage mothers or teenage girls who had experienced pregnancies handled the situation, which factors drove them to teenage pregnancies, the support mechanism available, and how they were able to get back to schooling.

2.4 Sampling Methods

The study used a purposive sampling to identify the 20 counties where FAWEK was implementing the program. From the 20 counties, the study further purposively identified the schools in which teenage pregnancies were reportedly high. The study further used the schools' heads or administrators or teachers on duty to purposively identify learners within the school surroundings for the cases where the schools were closed. In cases where the learners were still in school, the teacher on duty or the administrator randomly picked school-going girls in the schools. For the learners who were out of school, the snowball method was used to identify other learners, especially those who were teen mothers. From the schools, the administrators purposively picked girls and boys for the FGDs, while in the surroundings of the schools, the guide, through snowballing, helped identify girls for the FGDs. The KII members were selected purposively.

2.4.1 Non-Probabilistic Sampling Design

The non-probabilistic sampling design is the non-random selection of respondents based on convenience and not through scientific means. This design was used to select key informants for interviews (KIIs) and focus group discussion (FGD) members. Probabilistic sampling design was preferred as the KIIs offered expert opinion on the topic on teenage pregnancies, girlchild empowerment and education. Participants for FGDs and KIIs were purposively selected.

2.4.2 Probabilistic Sampling Design

The probabilistic sampling design is the random selection of respondents based on the scientific process. This sampling design process allowed the researcher to make strong statistical inferences about the whole group. In this study, probabilistic sampling design was used solely for the quantitative approach, where the number of respondents filling the questionnaires was established. In this case, the respondents included teenage girls and young women. A representative sample was selected from the targeted population involving different demographic characteristics. The calculation to find out the sample size for this study assumed a confidence level of 95%.

Based on the formula for an infinite but estimated population of the areas, the following Slovin Formula was used.

$n = N / (1+Ne2)$

Where:

n was the sample size,

N was the target population

e was the error term or the margin of error.

In our approach, we distributed the sample size into three key groupings: the target population in urban counties, rural counties, and ASAL counties. Based on these three groupings, each category had over 10,000 teenage girls who had experienced teenage pregnancy or child marriage. From this background, the following sample size was achieved.

n. = 10,000 / (1+ (10,000 *0.05^2)

n. = 10,000 / 1+25

n. =384.61, this was rounded off to the nearest whole number, getting 385 participants.

n. = 385.

With the three diverse groupings/categories (urban counties such as Nairobi and Nakuru; ASAL counties such as Kajiado, Garissa, Turkana, and Narok; and rural counties like Muranga, Kiambu, Machakos, Homabay, Migori, Siaya and Busia among the other counties), we multiplied the sample size by three.

n. = 385 x 3 categories = 1,155 participants.

n. = 1,155 participants, adding an allowance of 91 participants randomly selected to ensure each county had a minimum of 30 participants, the final sample size arrived at 1,246. The extra 91 participants were added to cater for non-responses and to balance the sample size distribution.

n = 1,246 participants

The sample size was proportionally distributed across all the counties based on the target population (see Table 2).

2.5 Sample Size and Response Rate for the Survey

The study's sample size distribution was based on the secondary data generated by the Number of adolescents presenting with pregnancy at the first antenatal clinic in 2020, according to the Office of the High Commissioner for Human Rights 2022.

Table 2: Sample Size Distribution and Response Rate

Counties	14-19 Year pregnant Total*	Adjusted sample for n<30	Frequency	Percent of sampled respondents
Bungoma	13376	84	82	6.8
Busia	5707	36	33	2.7
Elgeyo Marakwet	4004	30	55	4.6
Garissa	3168	30	35	2.9
Homa-Bay	11867	74	53	4.4
Kajiado	10872	68	66	5.5
Kakamega	14768	93	86	7.1
Kiambu	10382	65	55	4.6
Machakos	5432	34	61	5.1
Meru	14669	92	91	7.6
Migori	9342	59	56	4.7

Muranga	5519	35	33	2.7
Nairobi	22159	139	121	10
Nakuru	12450	78	63	5.2
Narok	15225	95	60	5
Nyandarua	2306	30	29	2.4
Nyeri	2380	30	30	2.5
Siaya	7758	49	74	6.1
Trans-Nzoia	11601	73	66	5.5
Turkana	8450	53	55	4.6
Total	191435	1246	1204	100

*Office of the High Commissioner for Human Rights 2022 and Kenya Health Information Management Systems

From the table above, the entire sample size proposed was 1,246 participants.

Table 2 shows the distribution of the participants. Nairobi (10%), Meru (7.6%), Kakamega (7.1%), and Bungoma (6.8%) had the highest proportions of teenagers and young girls interviewed.

A list of mapped schools in the respective counties where a high number of cases had been reported was provided by FAWE Kenya. Interviews were conducted for girls from the mapped schools, which accounted for 50% of the sample size and 50% from the community, not necessarily from the mapped school. The list had telephone contacts of head teachers from each school who were used to approaching the girls. In our sampling method, the priority participants were girls in the mapped schools who met the criteria of having experienced TP or CM.

Inquiries about whether there were cases of TP/CM were first made through the head teachers, and the data collection team would then look for girls and interview them. The remaining sample was of girls in the school, but there were neither TP nor CM cases. This sample included 50% of the girls allocated to that school. The second group (the other 50%) is the girls who are not necessarily schooled at that school but are residents of that community. We contacted village elders/CHW/chiefs to help identify the cases who had experienced TP/CM and interviewed them. Then, the remaining sample was administered to the other girls in the community who met the criteria and may not necessarily have experienced TP/CM.

2.6 Sampling Strategy for Qualitative Methods

Respondents for KIIs and FGDs were selected through a purposive sampling technique that involved identifying and selecting individuals or groups of individuals who are especially knowledgeable about or experienced in the issues of interest. Key Informant Interviews were administered to FAWEK and relevant stakeholders such as the Centre for Rights Education Awareness (CREAW), Ministry of Education (MoE), Ministry of Health (MoH), select/patron teachers, sampled teenage mothers, national and county government representatives, community and religious leaders, and law enforcement among other stakeholders. For FGDs, a group of 8-10 participants were identified and put together for each session. Specific consideration was given to ensure the participants were representative regarding gender, age, and other relevant local demographics like teenage mothers, and teenage girls.

Table 3: Distribution of Key Informant Interviews

Category of Key Informant	Number of KIIs planned	No. of KIIs done
FAWEK -M&E head, FAWEK- *Imarisha msichana* Project coordinator/ CREAW-M&E, CREAW- Program Officer and KRCS program officer	5	4
Ministry of Education (county directors of education -county staff), TSC staff, KICD)	3	3

Ministry of Health (County Chief officers, National government MoH Focal person, select county referral hospitals)	3	3
School Administrators/head teachers - in four counties	4	2
Children's Department (Children's officer)	2	2
Teenage mothers- for case studies	6	6
Media - covering youth and gender issues (TV personality &Media house manager)	2	1
National and county government administrators	2	2
Law enforcement agencies (police or lawyer)	2	2
Community champions and religious leaders	2	2
Totals	31	27

The following was the distribution of the FGDs. A total of 200 members participated in the FGDs.

Table 4: Distribution of Focus Group Discussions

Category of FGD Respondents	Number of FGDs sampled	FGDs Done	Totals Members
Teenage girls	6	6	60
Young girls	4	4	40
Young boys	4	3	30
Parents/guardians	4	4	40
Teenage mothers (not in school)	4	3	30
Totals	22	20	200

The selection of FGDs allowed the participants, especially girls and teenage mothers, to share more personal experiences and provide answers to research questions not explicitly answered in the questionnaires. FGDs were used to answer such questions as who was responsible for the pregnancy, the effects of teenage pregnancy on their schooling, and the impacts. Through using FGDs, teenage girls were able to open and provide answers to critical questions on TP and CM.

2.7 Data Collection

This section explains the data collection process in detail, including programming the data tools, recruiting the data collection teams, training the enumerators, and pretesting the tools.

2.7.1 Individual Household Survey Questionnaire

The individual household survey questionnaire was programmed digitally using the Kobo Collect application software. The digital tool was downloaded on smart phones that enumerators were using to collect data. The digital questionnaire had quality control features, including in-built skip logic, mandatory inputs, consistency checks, and a Global Positioning System (GPS) to enable geospatial mapping of the surveyed households.

2.7.2 Recruitment of Data Collection Teams

The data collection teams were recruited from within the different counties to ensure experienced and qualified locals were given the opportunity to participate in the study. The recruited team comprised supervisors, enumerators, FGD moderators, and note-takers. The selection of the team was based on the team's level of education, experience conducting similar assignments, and residence in the county of interest. The selection criteria for the research assistants were based on a bachelor's degree in social sciences, at least one year's experience in

doing social surveys, and a residence in the county where they were working. In addition, previous experience in using the KOBO Collect mobile app was an added advantage. Based on these selection criteria, the consultant identified the right candidates for the data generation process.

2.7.3 Training of Data Collection Teams

The consultants conducted a two-day survey team training focusing on the study protocol, data collection tools, research ethics, and interviewing skills, among other aspects. The training emphasized skills concerning digital data capture using the mobile phone app, ethical considerations, and interviewing skills. Teach-back methods and role plays ensured the trainees gained sufficient knowledge, skills, and confidence to undertake the survey. The translation of the tools was validated during the training session through back translation from English or Swahili to the local language.

2.7.4 Pre-testing of Data Tools

After the training, the individual survey team undertook pretesting of the study tools for the purpose of identifying aspects requiring adjustments. The exercise also offered an opportunity to practice interviewing skills with real-life respondents. The enumerators were first paired to help in answering the research questions. At the county level, each enumerator was assigned one potential respondent (learner) in selected schools that were not in the sample size. The enumerators then asked the pilot respondent questions. After the interviews, the enumerators were then convened for debriefing and discussing the formation and flow of questions.

2.8 Field Data Collection

This section explains the field collection process and the data quality approaches.

2.8.1 Field Data Collection

Individual household questionnaires, FGD, and KII guides were the key tools used in collecting primary data for this survey. Key deliverables and parameters for the survey were identified for triangulation purposes, and a desk review was conducted. This involved a review of project information and important project documents, relevant past reports, and important secondary data that were made available and others that were accessible online. Key Informant Interviews (KIIs) were administered to education experts, health experts, FAWEK, and stakeholders. The questionnaire consisted of five sections (A to E). Section A was for Demographic information; section B captured teenage pregnancies; section C captured child marriage; section D was for Tuseme Clubs; and section E was for Awareness and Media. The FGDs and KIIs had targeted questions capturing the five sections. The questionnaires were administered to school-going girls between 9 and 25 years of age and spread across 20 counties. The enumerators first visited the identified schools, from where they sought permission to interview the learners. In cases where the schools learning programs were in session, the principal/headteacher allowed the enumerators to pick girls in schools randomly. Since the exercise was carried out during the school holiday period, the school head gave the enumerators a guide (either a teacher or a Parents Association member) to take the enumerators around, identifying girls for the interviews. With assistance from guides, the enumerators identified and interviewed the allocated sample size per school per county until the sample size was achieved.

Data collection was carried out in the first two weeks of December 2022.

2.8.2 Data Quality Assurance

Data quality assurance was pursued using the following approaches:

a. Proper identification and training of enumerators: The consultants ensured the selection of highly qualified enumerators with at least a diploma and above in education and three years of experience in social research. This was the starting point for ensuring proper data quality.

b. Supervision: Each data enumeration team received direct supervision from one of the consultants to ensure that fieldwork was conducted as stipulated in each project guideline. The associate consultant had clear knowledge of the project under supervision. A supervisor was also recruited in the respective counties to keep the consultants informed and updated while the fieldwork was in progress.

c. Briefing: The data collection team was briefed on the General background of the project, an Explanation of the sampling procedure, an Explanation of the questionnaire (Question by Question), Dummy interviews to share the problems encountered, a Pilot interview with the respondents in the field, and a debrief on the pilot test of the tools. This ensured they had a complete understanding of the project, the use of data collection tools, and the implementation protocol of the study.

d. Accompaniments: The project staff accompanied 15% of the interviews. This was to ensure that the interviewer followed the instructions and procedures in the questionnaire sample specifications and conducted the interviews according to the specified standards. If problems were encountered, solutions were provided and explained to all the interviewers.

e. Checking Questionnaires and spot checks: The supervisors verified 100% of the questionnaires to ensure that answers to all questions were completed and the established data collection routine had been duly followed. The field coordinators made spot checks to ensure that both the supervisors and the interviewers were doing their work.

2.9 Data Preparation, Coding, and Analysis

The data generated through the FGDs and KIIs were transcribed verbatim and analyzed using the Nvivo software and thematic analysis techniques. The analysis was guided by the themes of interests identified that largely align with themes based on the study objectives, emerging themes, and the available literature.

For the individual survey, the dataset was downloaded from the server and converted into an Excel (.xls) file for easy exploration and cleaning. Data cleaning focused on eliminating outliers and cases with major flaws. The clean dataset was then exported to Statistical Package for Social Sciences (SPSS) software for analysis. A codebook containing information about each variable in the dataset was created. Both descriptive and inferential statistics were analyzed. As a first step, the analysis focused on descriptive statistics, including frequency tables and cross-tabulations of the variables of interest. Next, a more elaborate analysis was conducted, including correlations and statistical significance tests.

2.10 Ethical Considerations

The key research principles embraced during the data collection and analysis process were the safety of the respondents, non-discriminatory participation, anonymity, confidentiality, and informed written consent. In addition, FAWEK provided the team with a child safeguarding policy for reading and signing, which provided guidelines for dealing with children. Similarly, a letter from the Ministry of Education and FAWEK allowed the researchers to conduct the study, including data collection in schools.

The study paid attention to the key ethical issues as highlighted below.

a. Informed Consent, assent, and confidentiality: The following measures were taken as a continuous process to secure informed consent and assent of the participants: explaining the objective of the study, the kind of

information required and the intended use, and, above all, providing reasons for choosing the respondent. Once the respondent gave their permission, the enumerators would proceed with data collection. Research Assistants (RAs) explained to the participants in case of any arising issues concerning their security. Respondents were allowed to withdraw from answering questions at their will in case they felt uncomfortable with some questions. In summary, each respondent under 18 years old filled out an assent form, and the guardian/parent filled out the consent forms. The consent and assent forms were later shared with the client, FAWEK.

b. Privacy safety, anonymity, and confidentiality: To ensure privacy and safety, research participants were given fair, clear, honest explanations of what would be done with information that has been gathered about them and the extent to which confidentiality of records would be maintained. They were given an opportunity not to answer any question they did not want to answer. The research team also maintained the confidentiality of data and ensured no exposure to third parties by having passwords. The team observed adherence to children's protection and safeguarding standards by signing the FAWEK child protection policy. In scenarios where case studies were used or verbatim quotes were used, the names of the respondents were changed to hide their identities (anonymity), and the information collected was kept confidential.

c. Data Protection: As a consultancy firm, we are familiar with the Kenya Data Protection Act 2019 provisions.[6] The consultant ensured that the research team adhered to Part IV of the Act, which outlines the principles and obligations of personal data protection.

d. Child protection: The consultancy firm was conversant with the provisions of Child Protection and the appropriate and relevant legal provisions. The laws of the Republic of Kenya are deemed appropriate if any of the measures mentioned above were inadequate or inconsistent with the laws protecting children during the study. The research team (consultant, enumerators, and supervisors) was trained and conversant with all the requirements for a study and strictly adhered to the FAWEK Child Protection Policy and Code of Conduct.

2.11 Study Challenges and Mitigations Measures

a. Ongoing festivities: The unavailability of teenagers due to the December holiday and Christmas festive season was a major challenge. A good number of targeted participants (teenagers and young women) had traveled elsewhere for the festive season. To mitigate this, the enumerators managed to trace the learners who stayed within the surrounding communities, using snowball and random approaches.

b. Ongoing exams: There were ongoing Kenya Secondary Certificate of Education (KCSE) national examinations, some of the enumerators could not access the targeted participants. In many cases, enumerators had to wait until 2 pm to interview students in some mapped schools, while access was completely denied for others. The problem was solved by getting consent from the principal for all the interviewed participants and handling interviews from the school compound.

c. Unavailable parents: In some cases, enumerators collecting data from the community were not able to find parents or guardians; hence, no one gave consent for the interview, leading to skipping interviews. With parental consent, this problem was addressed by moving to the next household where present teenage girls met the inclusion criteria.

[6] https://www.odpc.go.ke/dpa-act/

SECTION THREE: FINDINGS AND DISCUSSIONS

This chapter presents a synthesis of the key findings of the survey, organized into seven main sub-sections: (a) Demographic information, (b)teenage pregnancies in Kenya, (c) Girls at risk of teenage pregnancy, (d) Magnitude of teenage pregnancy in the selected 20 counties.[7] (e) factors leading to teenage pregnancies, (f) Effects of teenage pregnancies on girls, (g) National laws and policies and by-laws on handling teenage pregnancies in Kenya, and finally, (h) Best practices in reducing girls' exposure to teenage pregnancies and child marriages.

3.1 DEMOGRAPHIC INFORMATION OF PARTICIPANTS

The section presents the demographic information that includes the age of the participants, whether one is attending school, the level of schooling, having any special needs and the family capacity to meet basic needs. The section further presents marital status of the participants, presence (and type) of any disability, and family size.

Table 5: Distribution of sample characteristics by various indicators (n=1030)

Variables	Categories	N	Percent
Age	9-15 years	230	22%
	16-17 years	374	36%
	18-25 years	426	42%
Currently in school	No	288	28%
	Yes	742	72%
Current Level of Education (In school)	Pre-Primary	3	0%
	Primary	245	36%
	Secondary	423	62%
	More than Secondary	17	2%
Have any disability	No	973	94%
	Yes	57	6%
Family able to address basic needs	No	320	31%
	Yes	710	69%

In terms of age, a significant number of participants at 42% were aged 18-25 years, while those aged 9-17 years formed 58% of the sample participants. In terms of schooling, a significant number were in school, forming 72% of the entire sampled participants, while the remaining 28% (n=288) had either dropped out of school or completed their primary or secondary education. In the school going category, 62% were in secondary schools, while 36% were in primary schools, 2% were in post-primary institutions (technical and vocational institutes). A further 6% of the schoolgirls had disabilities. In addition, 69% of the participants' families were able to address their basic needs.

3.2 TEENAGE PREGNANCY IN KENYA

> *"I can't comment about child marriages; it is less rampant, but* ***teenage pregnancies*** *in the area are quite high. We get a lot of children coming here for the pre-natal and ante-natal clinics, mostly between the ages of 14 and 17 years. So those girls are still in school; they are not yet married off, but they get pregnant in school. This forces them to drop out of school."* ***Nurse-in-charge, Kajiado MoH hospital.***

[7] Bungoma, Busia, Elgeyo Marakwet, Garissa, Homabay, Kajiado, Kakamega, Kiambu, Machakos, Meru, Migori, Muranga, Nairobi, Nakuru, Narok, Nyandarua, Nyeri, Siaya, Trans Nzoia and Turkana

The statement confirms that teenage pregnancy is rampant in schools, and it is a significant public health and social amongst girls aged 10-19 years. It is a major challenge for socioeconomic development as it deprives schoolgirls of the opportunity to further their education and attain their career goals. It also exposes young girls and their children to major health risks. According to the World Health Organization, *"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

According to the KNBS 2022 report, the national prevalence of teenage pregnancy was at 15%, with the high rates reported in the Rift Valley and Western regions. In comparison to the previous DHS (2014) report, where teenage pregnancy was 18%, the 15% (KNBS 2022) signifies a reduction in the national average. The reduction by 3% was witnessed within a period of eight years (2014-22), showing the progress made nationally towards reducing teenage pregnancy. Despite the reduction in the national average, teenage pregnancy has remained relatively high in some counties like Samburu, Marsabit, Narok, Turkana, and Kajiado compared to others.

DHS data showing a decline in teenage pregnancy is further corroborated by data collected by the Ministry of Health (MoH)- Kenya Data Health Information Systems[8]. For instance, a total of 1,156,221 cases of teen pregnancies were reported between January 2018 and December 2020. On a yearly basis, 427,297 cases were reported between January - December 2018, 396,924 cases were reported between January - December 2019, and 332,000 cases were reported between January - December 2020.

A report by UNFPA[9], indicated that there **was a spike in teenage pregnancies across Kenya during the COVID-19 pandemic lockdown**. A quick trend analysis shows that Nairobi County was leading with 11,795 teenage pregnancies from Jan-May 2020. This was slightly higher than the 2019 figures in the same period (11,410 cases). Kakamega County was second, with 6,686 cases compared to 8,109 cases (2019)[10].

The survey further established that teenage pregnancy among adolescent girls was on the rise between 2020 and 2021. Out of 100 girls sampled, 19.9% (about 20) teens were pregnant during the COVID-19 peak (2020 and 2021), as shown.

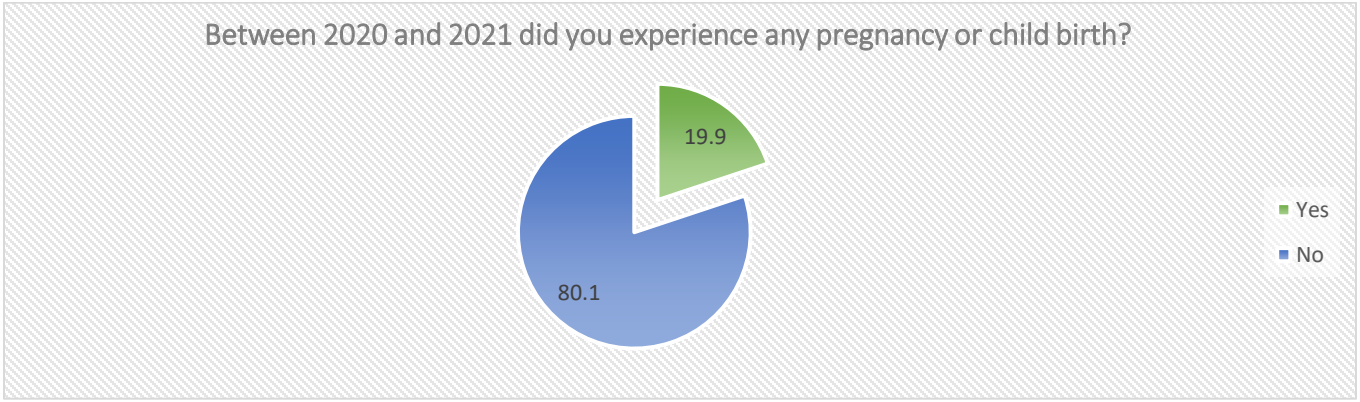


Figure 2: Teenage Pregnancy Rates

[8] https://dhismicro.org/disaggregated-indicators
[9] https://kenya.unfpa.org/en/news/breaking-silence-led-high-teenage-pregnancy-rate-kenyan-county
[10] https://www.afidep.org/news-release-teen-pregnancy-in-kenya-verifying-the-data-and-the-facts/#:~:text=A%20quick%20trend%20analysis%20shows,the%20period%20Jan%2DMay%202020.&text=From%20all%20the%20counties%2C%20the,the%20same%20period%20in%202019.

Even though the teenage pregnancy was reported at 19.9% in the 20 counties, the national teenage pregnancy rate stood at 15% from the household survey (KDHS:2022), indicating that the teenage pregnancy rate was 15%, declining from 18% in 2014.

3.3 GIRLS AT RISK OF TEENAGE PREGNANCY

Different situations in and out of school have put girls at risk of teenage pregnancy, especially girls out of schools, those with disabilities, living in poor or rural marginalized communities, living and working on the streets, and those hosted in Kenya as refugees and asylum seekers.

3.3.1 Out-of-school Girls

According to an Out-of-School Children Initiative study conducted in Kenya in 2020, almost 1.13 million children of primary school age (6 to 13 years old) were out of school in Kenya. The situation worsened due to the impact of COVID-19-related school closures, followed by drought, cost of living, and then floods in many of the focus counties. The prevailing situation makes out-of-school girls more at risk of teenage pregnancy because they lack basic education to help them make informed decisions. According to the household survey (KDHS:2022), 4 in 10 women aged 15-19 who had no education had been pregnant, compared to 5% of women with more than secondary education.

The survey established that Turkana County had the highest number of dropouts (34%) of girls, closely followed by Garissa (31%), Narok (27%) and Nairobi teenage school dropouts (at 26%). Machakos, Homabay, and Nakuru had the lowest proportions of school dropouts at 2%, 7%, and 10%, respectively. The dropout rate in the Asal areas (Turkana, Garissa, Narok), parts of Nairobi, and Nakuru was higher than the national dropout rate among girls, which stands at 6.5 compared to boys (5.9 %). According to the latest report by the Kenya National Bureau of Statistics, school-going girls in the country are likely to drop out at the age of 17, making them vulnerable to teenage pregnancy.

The survey established that dropout at the age of 17 years is attributed to the school environment, religion, the economic strength of families, insecurity, and broken families. For instance, it was established that 39.2% of the participants dropped out of school because of pregnancy, breastfeeding, or taking care of a baby. One girl said:

> *"You also find that people start judging someone. Someone does not know what situation led you to pregnancy and consequently dropping out of school. They start judging and start talking ill about you. Things like that."* ***Pregnant Teenage Girl, Nairobi County.*** On the other hand, ***"I am nineteen,*** *and I have one child. I'm not in school. I dropped out as I could not manage nursing the child and schooling simultaneously."* ***Teenage mother, Homabay County***

The survey also established that 27.7% of girls dropped out of school due to lack of money to pay for school activities. A girl from Garissa shared:

> *"When there are no school fees, and your family sees you as a big girl, parents arrange for you to get married. This leads to dropping out of school."* ***Teen school dropout, Garissa County.***

Other factors mentioned by the girls include getting married (25.1%), lack of interest in schooling (11.3%), and child labor (9.0%).

The other reason mentioned by the respondents included the ability of families to meet and address the needs of girls at school and home. A significant number (31.4%), felt their families could not meet their basic needs, including

education, as shown below. This was well pronounced in counties such as Turkana (49.0%), Narok (44.7%), Kajiado (48.9%), and Bungoma (45.6%).

Lack of basic needs for the girls was seen as exposure to the threats and a driver of teenage pregnancies among those girls with relatively unmeet basic needs. A girl from Turkana County said:

> *"I was staying in my aunt's place and I was not being fully supported, especially on getting my pads. So, my friend encouraged me to have a boyfriend to support me when need arose. After one month, I was pregnant, and my aunt chased me away to get married to the one who was responsible."* ***Teen school dropout mother, Kakuma, Turkana County.***

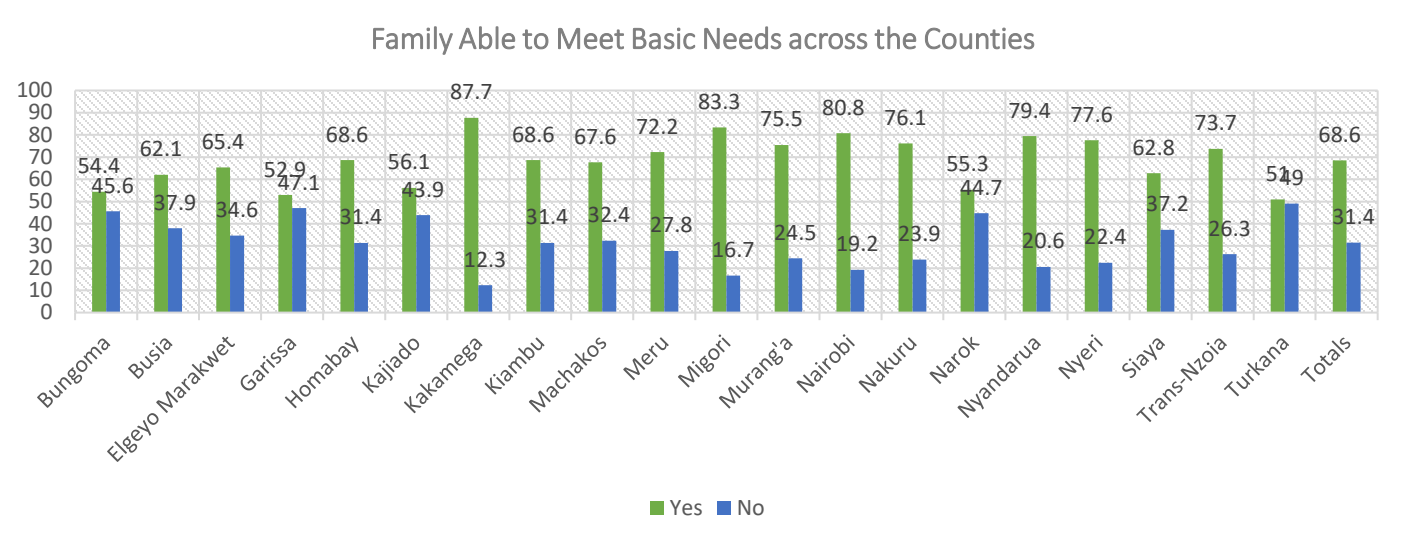


Figure 3: Family's capacity to meet basic needs

As shown above, a significant number of teenagers in Kakamega (87.7%), Migori (83.3%), Nairobi (80.8%), and Nyandarua (79.4%) indicated that their families were able to afford basic needs. On average 68.6% of the participants indicated that their families were able to meet the teenagers' basic needs.

Teachers and community members interviewed indicated that the school's environmental aspects, ranging from physical facilities, instructional materials, and approaches to teachers' attitudes, contribute to girls dropping out of school. They also pointed out the negative attitude of parents towards education. A girl from Nairobi County said:

> *"I was getting support from my father when I was in primary school. So, when I got to class eight, he said mothers are not supposed to study. That I should go back to whoever got me pregnant to support me in my education or I get married. He even instructed my mother, saying, "Sharon should not return to school. Because she has already given birth, let her fend for herself." My mother had made up her mind that I should drop school."* ***Teen mother, Nairobi County girls FGD.***

At the same time, headteachers and education officers interviewed indicated that **gender-based violence** was a major contributing factor to girls dropping out of school in the selected counties. According to one head teacher, GBV was noted to have increased from the COVID-19 period.

Most of the respondents agreed that the drop-out situation worsened during COVID-19, followed by drought in many of the included ASAL counties, which led to school closures. The study further revealed that in all the counties visited, these factors disproportionately affected girls, leading to their higher dropout rate.

3.3.2 Girls with Special Needs

Data from the survey shows that about 6% (n=57) of the learners aged 9 to 25 years had special needs, with a high prevalence among teenagers (13-19 years). Among the most common forms of special needs recorded in this study included physical impairments, sensory impairments (visual and hearing), intellectual disabilities, and learning disabilities. The number and types of special needs could be associated with the number of selected special schools in the sample size. The rate of respondents with special needs in this study was lower than 11% quoted from the National Survey on Children with Disabilities and Special Needs in Education (2017) by the Ministry of Education, among children enrolled in primary schools.

According to a 2014 study by the African Child Policy Forum (ACPF), girls with disabilities in Kenya are less likely to receive an education compared to boys with disabilities. The study highlights that girls with disabilities are often kept at home due to societal expectations and concerns about their safety and well-being. This exposes girls with disabilities to teenage pregnancy and early marriage.

According to those interviewed, the Government, NGOs, and international organizations have been working to improve the inclusion of children with disabilities in the education system. This includes policies aimed at inclusive education, teacher training, and the provision of assistive devices and learning materials. Despite these efforts, challenges remain regarding resource allocation, implementation of inclusive education policies, and addressing cultural attitudes towards disabilities.

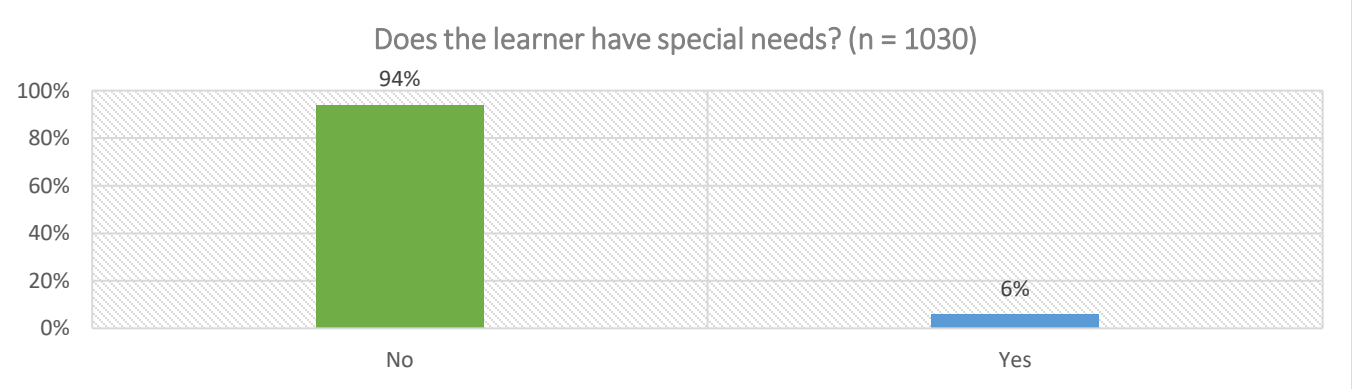


Figure 4: Learners with special needs

3.3.3. Girls - School Absentees

As of 2024, the school attendance rate for girls in Kenya has seen significant efforts and improvements. According to the survey, Machakos (98%), Homa Bay (93%), and Nyandarua had the highest school attendance. Turkana (66%), Garissa (69%), and Nakuru (70%) had the highest absenteeism. The high absenteeism was associated with factors like lack of school fees, lack of menstrual products, and teenage pregnancies.

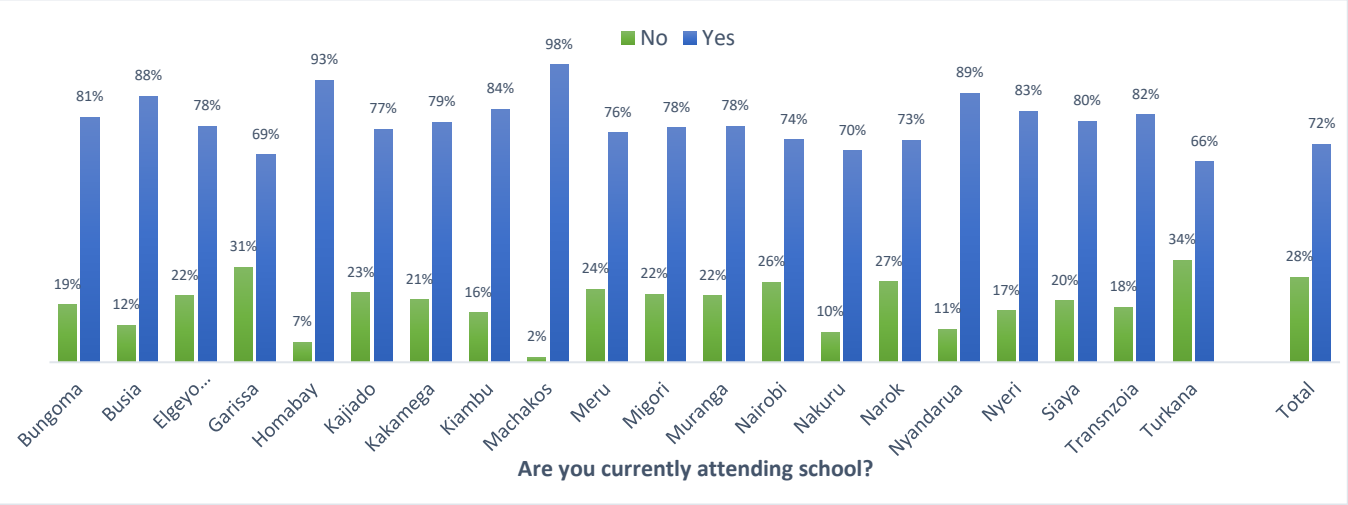


Figure 5: School Attendance

During the study, low attendance was attributed to lack of school fees (27,3%), teenage pregnancies (39.2%), and loss of interest in education (11.3%) due to low academic performance, negative attitude to some subjects and school. Other factors included unaffordability of sanitary products, lack of proper sanitation facilities, gender-based violence, long distances to school, and corporal punishment. These factors deterred regular attendance, leading to frequent absenteeism. A girl from Garissa County said:

> *We had to move away from where we were schooling in Fafi, and when we came to Mbalambala, I was forced to stay at home looking after my siblings and doing domestic chores."* ***A 15-year-old female, Garissa County.***

The survey noted that these practices are more prevalent in certain regions, and they affect more girls than boys, hence contributing to higher dropout rates amongst girls.

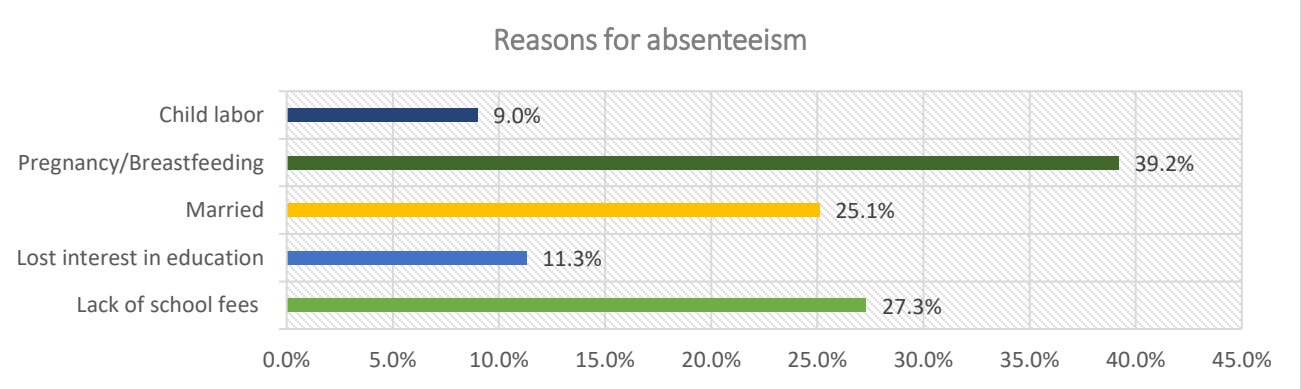


Figure 6: Reason for absenteeism

3.3.4 Girls -Not progressing to the next classes

Further, data from the Basic Education Statistical Booklet (2020) shows a trend in Kenyan schools where girls' enrollment always rises from grades 4 to 7. However, as shown in Figure 7, schools experienced a steep decline as the teen girls transitioned to progressed 8.

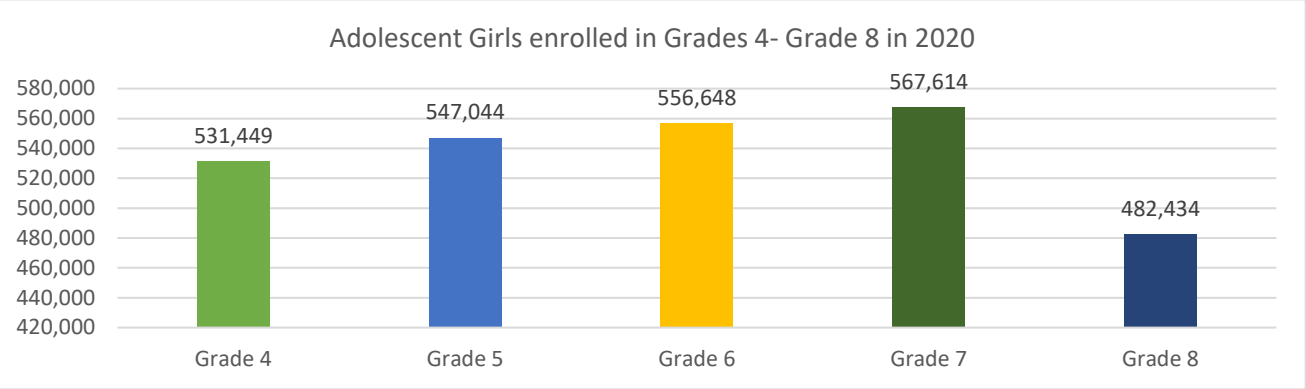


Figure 7: Adolescent girls enrolled in grades 4-8

The figure above shows that an estimated 15% of girls who enrolled in grade 7 failed to enroll for grade 8 in 2020. This could have been attributed to several factors. According to UNICEF, the low transition of girls to secondary education is attributed to girls being over-age for their grades (UIS, UNICEF, 2015)[11]. Other factors include sickness, death of parents causing grief and trauma, lack of school fees, lack of school supplies, child labor, parents' low perception of the value of education, community attitude towards education, lack of sanitary pads, early marriages, gender-based violence, and harmful practices -FGM.

3.3.5 Girls from Specific Geographical Areas.

According to the Basic Education Statistical Booklet (2020), some of the ASAL counties and informal settlements are likely to have a lower gender parity index, implying gender disparity in favor of boys. However, some counties such as Isiolo, although being an ASAL county, have had gender disparity in favor of girls, and this may continue. In terms of County analysis, counties with the lowest GPI at the primary education level were Mandera (0.60), Garissa (0.73), Wajir (0.77), Turkana (0.89), and Samburu (0.90). Some of these counties are also the least populous counties. According to the Kenya Population Census (KNBS, 2019), the least populous counties have many factors that put girls at risk.

The census further identified the most populous counties: Nairobi, Kakamega, Bungoma, Nakuru, and Kiambu. (KNBS: 2019). These counties have informal settlements, which put girls at risk.

Moreover, more girls in the rural poor are at risk of teenage pregnancy than girls from the urban centers. Another study shows that girls living in rural areas are more likely to be married in childhood than girls in urban areas. In 2022, for instance, 16% of teenagers (ages 15-19 years) had been pregnant in rural areas, while the prevalence was lower, with 12.3% of teenagers in urban areas.[12].
According to UNFPA, poverty, whether in rural or urban areas, puts girls at risk of teenage pregnancy. The UNFPA report indicated that adolescent pregnancies are more likely to occur among poor communities (21%) of women aged 15-19 in the lowest wealth quantile reported to have been pregnant, as compared (8%) in the highest wealth quantile.

3.3.6 Refugee Girls and Asylum Seekers.

From secondary literature, urban and rural refugee camps such as Kakuma and Dadaab host millions of girls who, at a tender age, were driven out of their homeland by civil wars, drought, cultural practices, gender-based violence,

[11] UNICEF-UIS Global Out-of-School Children Initiative Operational Manual (2015).

[12] https://www.statista.com/statistics/1446242/share-of-teenage-pregnancies-in-kenya-by-situation-and-residence

fear of abduction by militia, fear of early marriage, and Female Genital Mutilation. These girls are uprooted from their homes, separated from family members, isolated from their communities, and without the protection of their governments, they become excluded and disconnected from parental and community care systems. These conditions put refugee girls and Asylum seekers at risk of teenage pregnancy.

3.4 THE MAGNITUDE OF TEENAGE PREGNANCY IN SELECTED COUNTIES

The study sought to establish the present state of teenage pregnancies in the selected twenty counties in Kenya. According to the survey, teenage pregnancy is high in counties across the country and has remained so for some time now despite the periodic outcry when statistics on teenage pregnancy are released. However, it is important to note that the situation varies by county, with some counties being disproportionately affected than others.

According to the survey, the average **teenage pregnancy rate for the twenty counties was 19.9%.** This rate is significantly higher than the national average of 15% (Kenya Demographic and Health Survey: 2022). In terms of counties, Narok has the highest rate (43.3%), followed by Kajiado (35.6%) and Turkana (34.2%) in teenage pregnancy with adolescent girls aged (15-19). For instance, Narok North, Narok South and Kilgoris sub-counties had recorded the highest teenage pregnancy rates. In Turkana County, Turkana West (Kakuma), Turkana South (Katilu) and Turkana Central) had registered some of the highest teenage pregnancies. The three counties are characterized by high poverty, marginalization and they are pastoral in nature. Other counties that had TP rates above the national average and the twenty-county average were Siaya (26.7%), Homabay (25.2%), Meru (25%), Migori (24%), and Busia (21%).

The distribution of teenage pregnancies per county was as shown.

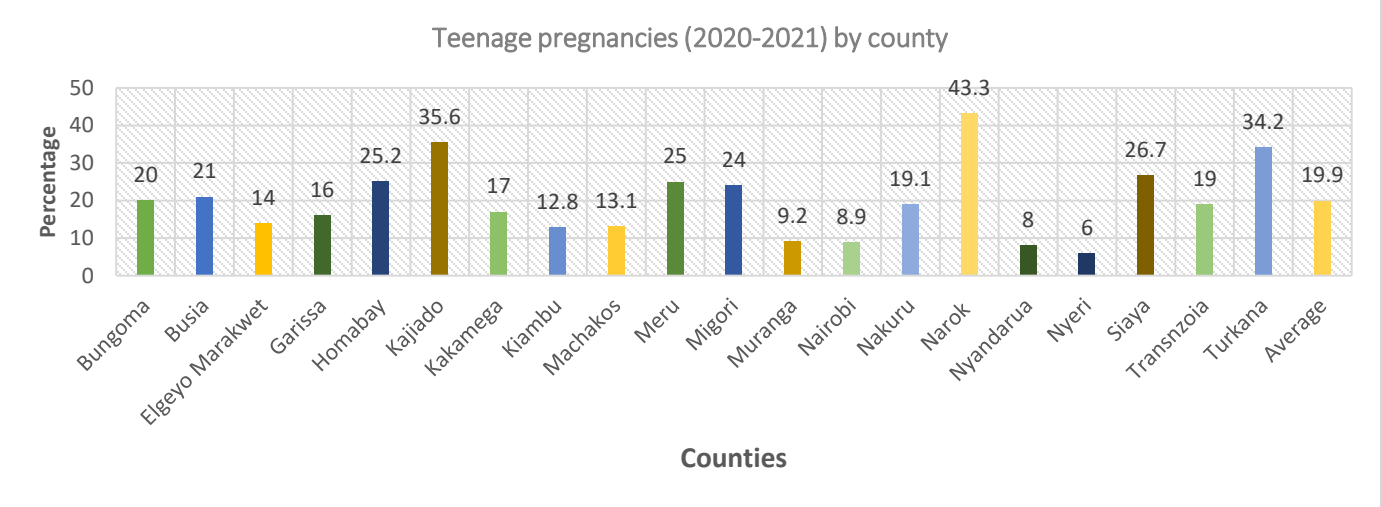


Figure 8: Teenage pregnancies by counties

The study further established that seven counties of Nyeri (6%), Nyandarua (8%), Nairobi (8.9%), Muranga (9.2%), Kiambu (12.8%), Machakos (13.1%), and Elgeyo Marakwet (14%) have recorded lower than the national average of 15%.

Importantly, the survey established that teenage pregnancy was **prevalent among girls aged 15-18** years at 27.4%, followed by 19-25 years (23.7%). A nurse in one of the hospitals confirmed by saying:

> *The ages that I find mostly here in antenatal clinics is between 15 and 17 years."* ***A nurse at Kajiado hospital.***

The reduction in teenage pregnancies in Kenya has been gradual, albeit with concerted efforts from different players; government institutions and non-governmental organizations. The TP rate was 21% from 2014 DHS[13], having reduced by 6 percentage point to 15% in 2022. The data shows that the protective effect of education has led to significant reduction in teenage pregnancies. Similarly, the reduction in unmet needs for menstrual health from 26% in 2008 to 14% in 2022 also accounted for significant reduction in teenage pregnancies.

Specific to 2014 DHS, Narok had the highest TP rates at 40%, followed by Homabay at 33%, then West Pokot (29%), Nyamira (28%) and Tana River (28%). In relation to this current study on teenage pregnancies in 20 counties, Kajiado had 20%, Migori (24%), Nairobi (17%), and Turkana at 20%. In comparison to the 2022 DHS, there were changes in the TP rates, some counties recording higher rates compared to others. This is shown in table below.

Table 6: Changes in Teenage pregnancies between 2014 and 2022

County	2014 DHS TP Rates	2022 Ever-been pregnant (TP)	Percentage Change
Bungoma	14	18.6	4.6
Busia	21	18.3	-2.7
Elgeyo Marakwet	9	12.1	3.1
Garissa	10	14.8	4.8
Homabay	33	23.2	-9.8
Kajiado	20	21.8	1.8
Kakamega	19	15.1	-3.9
Kiambu	14	11.9	-2.1
Machakos	14	11.3	-2.7
Meru	20	23.6	3.6
Migori	24	23	-1
Muranga	6	7.4	1.4
Nairobi	17	8.4	-8.6
Nakuru	18	17.3	-0.7
Narok	40	28.1	-11.9
Nyandarua	10	5.2	-4.8
Nyeri	7	4.5	-2.5
Siaya	17	20.9	3.9
Transnzoia	23	17.8	-5.2
Turkana	20	18.5	-1.5
Total	**17.8**	**14.9**	**-2.9**

There were seven counties that had an increase in teenage pregnancies as shown in the table. Garissa, Bungoma, and Siaya had an increase of teenage pregnancies by 4.8%, 4.6% and 3.9% respectively. This shows an increase in TP despite the actions and implementation of policies to reduce TP rates by various stakeholders.

[13] https://ncpd.go.ke/wp-content/uploads/2021/10/Advisory-Paper-3-Impact-of-Teenage-Pregnancy-on-Women-Empowerment-in-Kenya.pdf

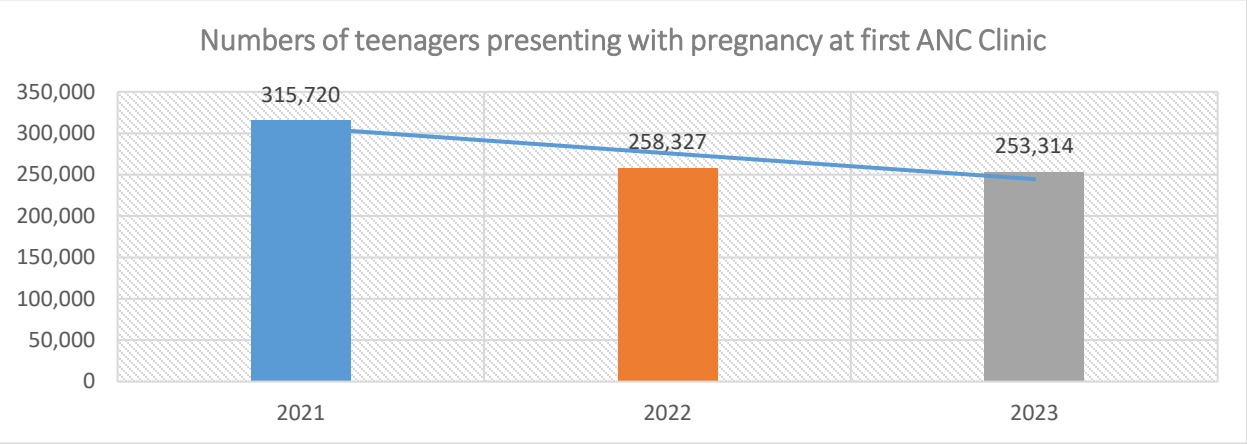


Figure 9: Numbers of teenagers presenting with pregnancy at first ANC Clinic from 2021 to 2023

As of 2024, the KNBS Economic survey[14] shows that there has been a reduction in teenage pregnancies. The number of school-going girls presenting with pregnancies at the first Ante-natal clinic (ANC) in 2021 was 315,720. This reduced by 22.2% to 258,327 in 2022 and further by 2.0% to 253,314 in 2023. This shows a decrease in the overall teenage pregnancies across all the counties. The higher numbers of teenagers pregnant in 2021 could be associated with the effects of Covid-19 effects on schoolgirls, including prolonged stay at home.

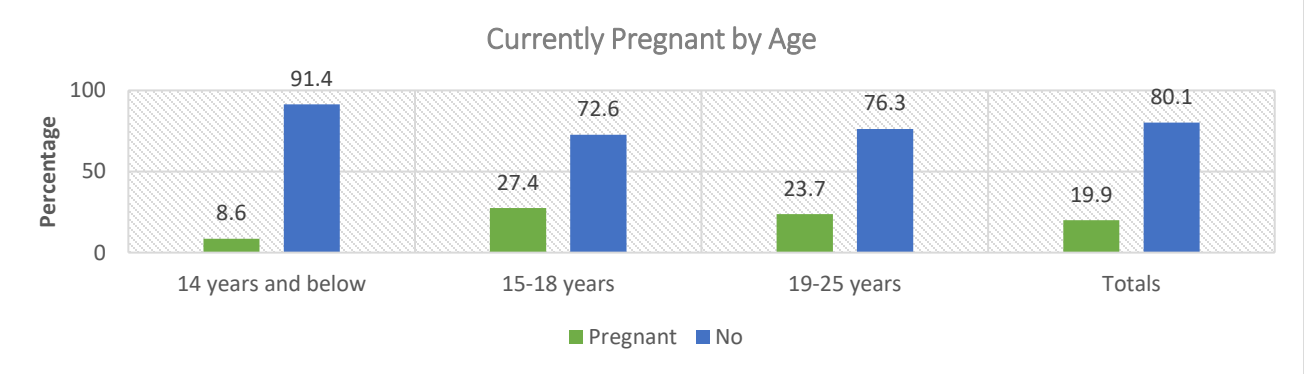


Figure 10: Distribution of pregnancy by age

While the age group of **9-14 was the lowest** in terms of pregnancy rate, the Population Policy for National Development indicated that there are nearly 6,400 births per year among girls aged 10-14. This trend among the 9-14 years could see more maternal deaths if not checked and curbed, it also raises alarm as the girls' reproductive systems are not fully formed, and thus are exposed to more adverse pregnancy complications, including complications like fistula and fatalities during delivery.

In terms of the **levels of education** most affected, the survey established that most of the teenage pregnancies (25.9%) were experienced among primary school-going girls, followed closely by 23.8% of those in secondary schools, as shown Figure 11.

[14] https://new.knbs.or.ke/wp-content/uploads/2024/05/2024-Economic-Survey.pdf

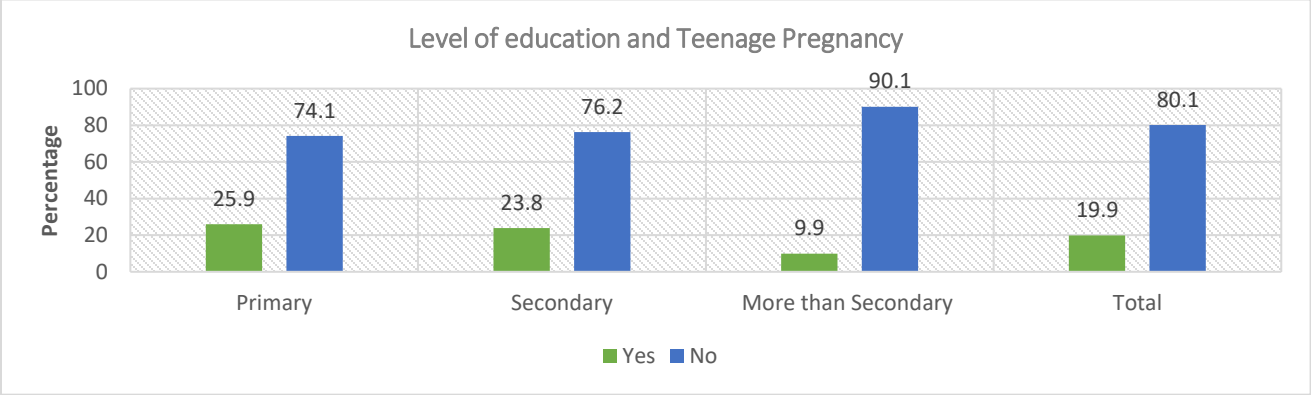


Figure 11: Teenage pregnancy by education level

This further confirms that primary and secondary schools should be prime targets for preventive strategies, with more efforts needed in primary schools.

In terms of perpetrators of teenage pregnancies, the survey established that the top three perpetrators of teenage pregnancies were boyfriends in school (29.1%), followed by neighbors (18.4%), and relatives (10.6%). *Boyfriend was a term used to show a consensual relationship between the girls and the boys. Boyfriend meant a classmate, a schoolmate, or another young boy from a nearby school or college. The least of the persons responsible for teenage pregnancies were strangers (4.3%) and older adults (termed as sponsors, including teachers, policemen, pastors, and priests) were associated with 5.7% of teenage pregnancies, as shown below.

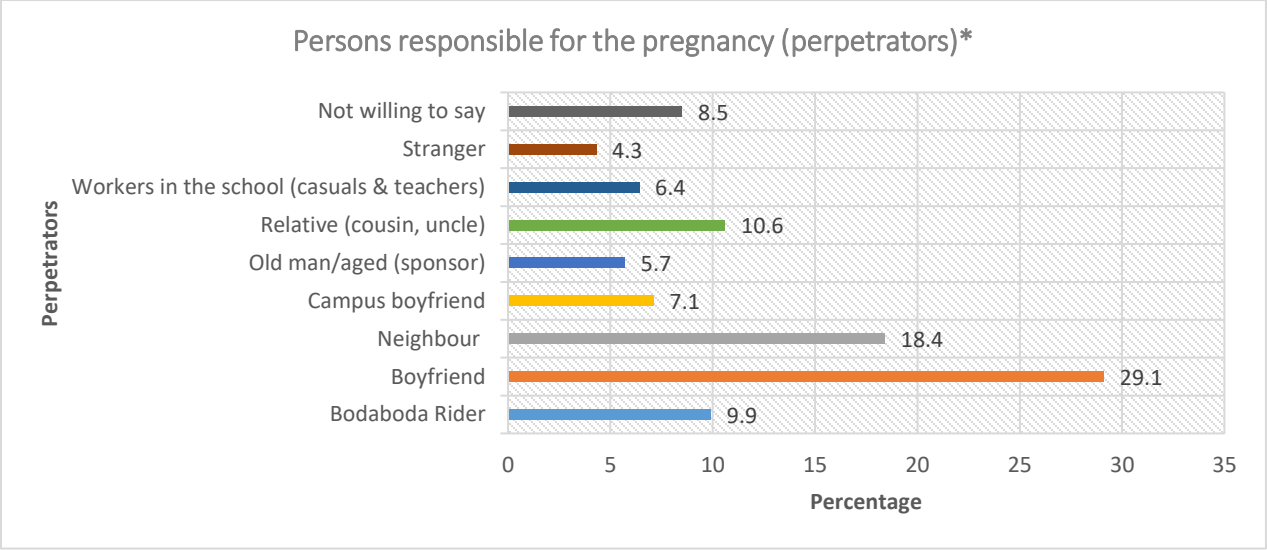


Figure 12: Perpetrators responsible for pregnancy

According to the girls interviewed, most pregnancy cases **are student-by-student pregnancies**. A girl in Kakuma said:

> *"Here in Kakuma, I saw several of my friends drop out of school and get pregnant. I also fell victim as I spent most of the time at home, and my mother was away working. I spent a lot of time with my boyfriend, and after two months, I realized I was pregnant." A* **15-year-old girl in Katilu, Turkana County (through a case study).**

However, according to key informants, no action is always taken against boys and adult men who impregnate girls. In fact, according to the BOM members, some parents get happier when they hear or come to learn that their sons

have impregnated girls. Such sons are considered heroes and not villains. According to respondents, any attempt to punish such boys in some communities is met with vengeance by parents and the community. From these findings, interventions targeting boys in primary and secondary schools can be fruitful in reducing incidences of teenage pregnancies.

In terms of places where pregnancy occurred, the study noted that most of the sexual acts leading to teenage pregnancies were experienced at the homes of the perpetrators (boyfriends, teachers, police, priests, or friends).

The following were some of the quotes on the places where pregnancies occurred.

> *My boyfriend and I were from the market, then when the darkness came, he convinced me that I should not go home because my parents would not open the door for me. We went to this house, and after one month, I realized I was pregnant.".* ***16-year-old girl in Bungoma County***

Other places preferred included forests, lodges, and guest houses. One of the girls had this to say,

> *My boyfriend was a motorcyclist, and on many occasions, we had sex inside the Forest or sometimes by the roadside without any protection."* ***15-year-old girl in Kakamega County.***

Another girl testified,

> *My Boyfriend, who is a lorry driver, took her to a lodging in Kiminini, and on another occasion, a guest house in the neighborhood."* ***16-year-old in Bungoma County.***

The testimonies show the vulnerability of girls and Boys, according to those interviewed, capitalized on events like birthday parties, night vigils (matanga and kesha), and children camps sponsored by churches during the school holidays to engage in sex. According to teachers interviewed, most pregnancies occur during school holidays.

3.5 FACTORS CONTRIBUTING TO TEENAGE PREGNANCIES

This section focuses on factors significantly contributing to teenage pregnancy. Participants identified the following as the major factors leading to teenage pregnancy. However, in the discussion below, some of the actors have been either grouped together or renamed due to their orientation.

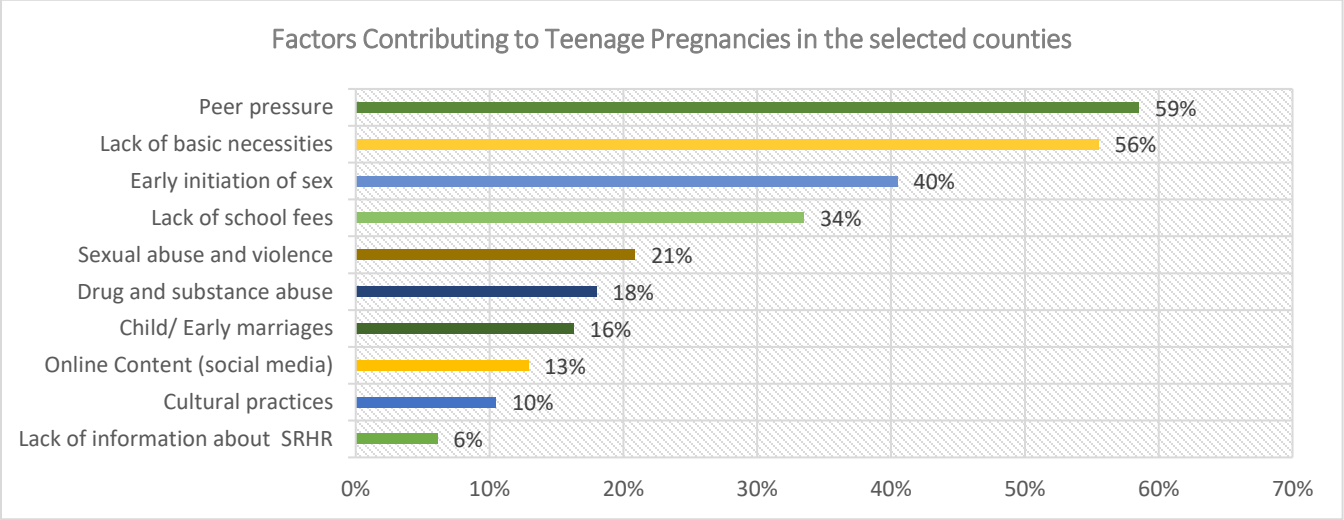


Figure 13: Factors Contributing to Teenage Pregnancies in the selected counties

3.5.1 Early Sexual Debut (early Initiation of Sex)

Early sexual activity was high among adolescents and youth in Kenya as shown from the survey data. The data revealed that 59% of teenage girls were influenced by their peers to have boyfriends and engage in sex. Early sexual debut was highest in Homa Bay 34%, followed by Migori (31%), Machakos (32%), Nairobi (29%), Siaya (29%), Bungoma (28%), and Meru (27%). However, it was low in Nakuru County at 17%.

A girl in Kakuma said:

> *"In my case, I was influenced by my friend, who was getting financial assistance from her boyfriend. She then arranged for a friend of her boyfriend to meet me. Since then, we became friends, and became pregnant,* an expectant 16-year-old schoolgirl, Kakuma, Turkana.

KDHS data[15] show that the 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), the median sexual debut in ASAL counties is ten years.

About 12% of girls and 22% of boys reported having had sex by the age of 15. Peer pressure, the survey realized, created an environment leading to boys and girls in engaging in early sex in the five counties. Homabay County recorded a high score in peer pressure at 40%, followed by Siaya County (38%), Trans Nzoia (34%), Busia County (33%), and Kiambu (32%) Bungoma (29%). Nairobi at 29% and Meru at 27% showed that peer pressure was the main reason for the early sexual debut. However, peer pressure was lowest in Nakuru, Migori, and Nyandarua at 22%.

3.5.2 Social Media Influence:

Social media was mentioned as a critical factor that created an enabling environment for teenage pregnancy. On average, across the five counties, 17.8% of the participants indicated that social media access was a significant contributor to teenage pregnancy. However, this varied from county to county. Turkana county recorded the highest score of 26%, followed by Trans Nzoia (23%), Nakuru (23%), Muranga (21%), Kiambu (19%), Narok (19%), and Nairobi (18%). However, social media was the lowest in Machakos (15%). Access to online content and social media platforms using phones and the Internet was found to enable communication between boyfriends and girlfriends, creating a high likelihood of early initiation of sex and, consequently, teenage pregnancies. From the qualitative data, the following were some of the quotes supporting the leading factors for teenage pregnancy in the three counties.

3.5.3 Lack of Parental Supervision

Lack of parental supervision was mentioned as another factor that contributed to creating an environment that enabled girls and boys to engage in sex. Girls further attributed high pregnancy to poor parenting and moral decay. A girl from Nairobi County said:

> In my opinion, *the parents are the ones who contribute to teenage pregnancy. For example, you may find the parent harsh in the house and insults the teen daughter. The girl then decides to leave the house and seek comfort from friends, including boyfriends, who increase the chances of TP.* ***19-year-old teenage mother, Nairobi City County***

[15] https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf

Teachers supported this sentiment by similarly blaming teenage pregnancy on parental neglect of girls. According to teachers interviewed, sex amongst boys and girls has increased because of lack of parental care and guidance and loss of values and morals by adult men. A girl from Nairobi County said:

> *Parents also contribute to teen pregnancies, especially when a mother separates from the father and gets married to another man. The stepfather does not consider you as his child, and so he rapes you because he does not care.* ***Teenage mother, Nairobi County***

3.5.4. Inadequate access to family-life information:

Inadequate information on family-life (access to age-appropriate SRHR) was mentioned as the leading driver of teenage pregnancies across the five counties. The findings revealed that 56% of the girls had limited knowledge of family-life, hence leading to unintended pregnancies. This varied from county to county, with Busia County (36%) having the highest number of girls with inadequate information, followed by Migori County (35%), Siaya (32%), Bugoma (32%), Nyandarua (32%) Homa Bay (30%), Trans Nzoia (30%), Kiambu (30%), and Nakuru (21%). The study noted that Nyeri (17%) had the least number of girls with appropriate SRHR information.

One girl from Migori said:

> *We want to delay pregnancy or stop having children, but we are not using a modern method to delay pregnancies due to inadequate access to family-life information and the misconceptions that some of them lead to cancer.*

Girls interviewed indicated that in addition to accessing family-life information, they face barriers such as restrictive laws and policies regarding the provision of family-life information based on age or marital status, health worker bias, and financial constraints.

Additionally, adolescents may lack the agency or autonomy to ensure and benefit from the family-life information.[16]. According to KNBS (2015), use of modern methods of delaying pregnancies and childbirth are lowest among 15-19-year-olds and is known to increase with education. Nationally, only 40%[17] of adolescents have access to modern methods of delaying childbirth.

3.5.5. Inadequate Access to Education:

According to the survey, the lack of school fees, as mentioned by 34% of the girls, is a significant reason that exposed girls to teenage pregnancy. Lack of school fees was associated with girls staying at home, which increases their exposure to teenage pregnancies. Moreover, the lack of school fees is attributed to gender disparities in access, completion, and transition in favor of boys. Lack of school fees was very prominent in Turkana (48%), followed by Garissa (38%), Busia (32%), Homa Bay (28%), Bungoma (27%), Nyeri County (26%), Machakos (24%), Narok (20%), Nyandarua (18%), Nairobi (21%) and least in Meru (19%). While there has been increased primary school enrolment in recent years in Kenya. Currently, girls who have received minimal education are five times more likely to become pregnant than those with higher levels of education. For instance, teenage pregnancies are linked to lack of education and information about SRHR. In many places in the ASAL regions of Kenya, girls have limited options and opportunities for educational and employment prospects, hence are forced by circumstances to drop out of school, increasing their exposure to child marriage and teenage pregnancies. In such societies,

[16] https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy
[17] KNBS (2015): KDHS, 2014

motherhood is often valued, and marriage or union and childbearing are considered the best of the limited options available.

3.5.6 Culture and Tradition

Culture and tradition, especially Female Genital Mutilation (FGM), affects the physical and psychological health of girls and decrease their school attendance and performance.; fails to meet their gender equality rights; and risks their lives at the time of FGM. According to the survey, 40% of the girls mentioned initiation or FGM as a major factor driving teenage pregnancy. This varied from county to county, with Garissa leading (52%), followed by Turkana (42%), and Kajiado County (37%). This is above the national figure of 21%. However, counties such as Busia (12%), Homa Bay (9%), and Migori (2%) had a smaller proportion of girls affected by the culture. According to UNICEF (2020), FGM varies from 98% in the Northeastern region to 1% in the Western region.[18]. UNFPA indicates girls living in rural areas, in poor households, with less education, or who identify as Muslim are more likely to undergo FGM. Hence, the practice is highly concentrated in the Northeastern region and certain ethnic groups of Kisii, Kuria, and Maasai.

It is important to note that Kenya has made progress in accelerating the abandonment of FGM. According to various Demographic Health Surveys conducted in Kenya since 1998, there is a reducing trend in the practice of FGM among 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[19] and the government has identified 22 hotspot counties with the aim of shifting social and gender norms that perpetuate FGM and other harmful practices such as child marriage. However, threats such as the increased medicalization of FGM and loss of social protections have ensured the continuation of the practice.

3.5.7 Child Marriage

One of the major causes of the high teenage fertility rate in the country is early marriage or child marriage. The KDHS (2014) indicates that child marriage is a major cause of teenage pregnancy. About 60% of the participants indicated that there were many cases of child marriages in their community. Another 16% indicated that there were no cases of child marriages, while another 24% were not sure. About 60% of known cases point to the high prevalence of child marriages across the counties, an issue that needs to be addressed.

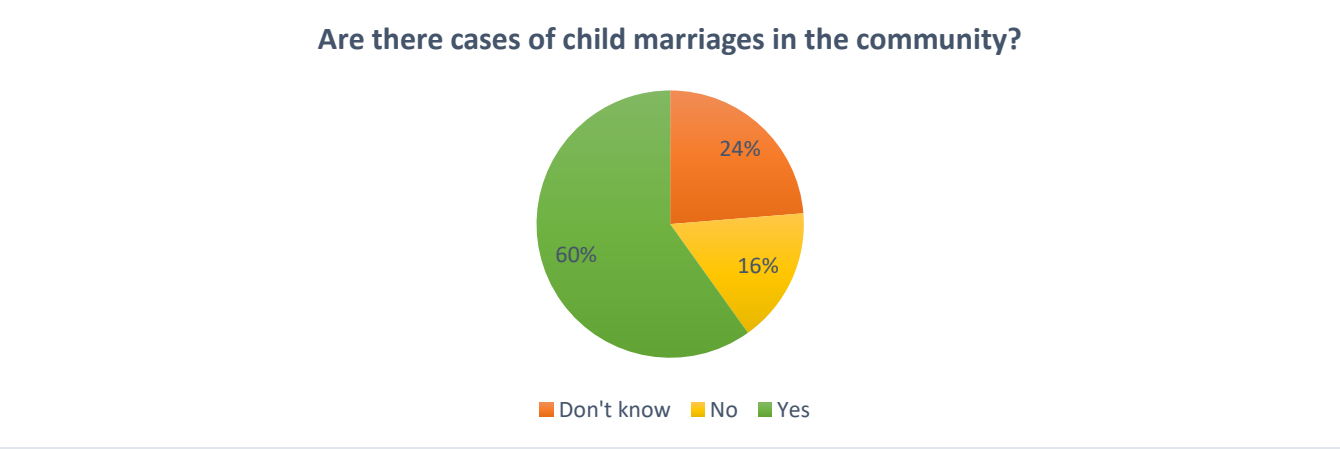


Figure 14: Cases of child marriages in the community

[18] https://data.unicef.org/wp-content/uploads/2020/03/Profile-of-FGM-in-Kenya-English_2020.pdf
[19] 28 Too Many. (2013) Country Profile: FGM in Kenya

Most of the teenagers (75%) interviewed acknowledged knowing between 1 to 5 child marriages in their area. The knowledge of the existence of about one to five-child marriages indicates that the practice is prevalent and common in society.

According to the survey, child marriage was prominent in Garissa at 43%, with Turkana coming second at 38%, Nairobi (22%), and Meru (14%). Available data shows that despite legal pronouncements, the proportion marrying by age 15 has not reduced since the 1990s. According to the KDHS (2014), 4.4% of girls aged 20-24 had married by age 15, and 23% were married by age 18. However, the survey established that 18.6% of those aged between 15-18 were in child marriages, signifying a reduction from 23% (KDHS:2014). On the other hand, 3% of boys in Kenya are married before the age of 18 years.

The worrying trend is the revelation by the survey that 9.1% of those aged 14 years and below had engaged in child marriages, indicating a need for intervention The government of Kenya has always been keen on reducing adolescent birth rates, and therefore, the earliest age for 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.

The main factors leading to child marriages were poverty (59%), teenage pregnancy (49%), and lack of access to education (42%). Other factors mentioned were cultural traditions, social norms, and poverty.

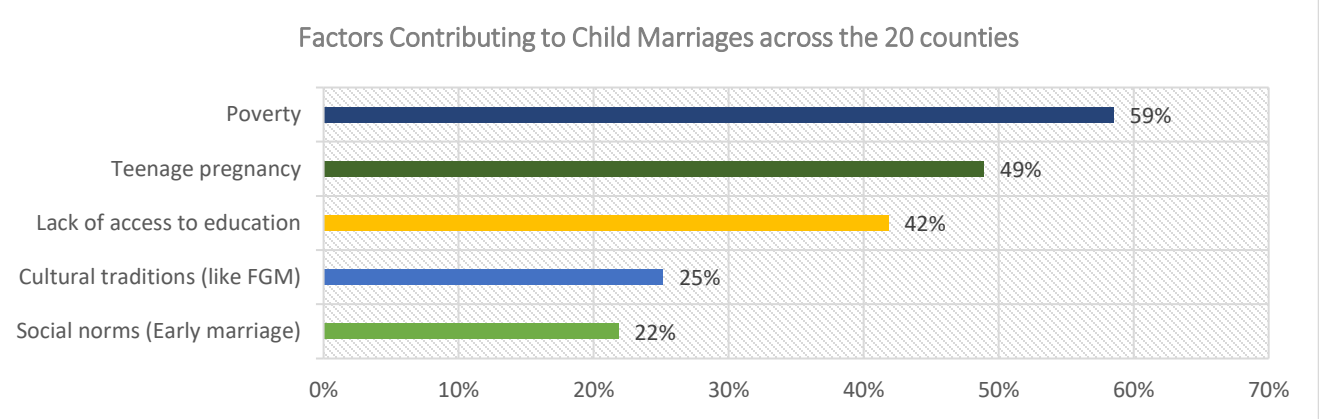


Figure 15: Contributing factors to child marriages

The causes varied from county to county. For the seven counties in Western and Nyanza regions, both access to education (30%) and poverty (30%) were the leading causes of child marriage. Teenage pregnancy came third at 21%, leading to child marriages.

In the ASAL counties, it was established that the five causes of child marriages included culture and traditions (32% in Kajiado, 29% in Narok, and 22% in Turkana). Confirming the influence of culture on child marriage, a teenage mother in Kajiado said:

> *You know, there are those cultures where the girls would undergo FGM. And once that happens, they're considered ready for marriage. Or they would then now be considered as grownups old enough to engage in sexual relations with the men. This could lead to pregnancy and consequently marriage."* ***18-year-old teenage mother, Case study, Kajiado, Kajiado County***

Cultural influence was followed by teenage pregnancies (29% each in Turkana and Kajiado and 26% in Narok Counties). Lack of access to education (as caused by lack of fees) contributed to 18% of reasons for child marriages in Narok and Turkana and 12% in Kajiado County.

In the Central counties such as Muranga, Nyeri, Nyandarua, Meru, Kiambu, and Nakuru County in Rift Valley, it was established that they have similar factors leading to child marriage. Poverty contributed to 49% of child marriages in the six counties; teenage pregnancy (18%) and lack of access to education (17%) were the second and third significant causes of child marriage.

The scenario in Nairobi, Machakos, and Garissa Counties was the same. Teenage pregnancies were the leading causes of child marriage in Nairobi and Machakos Counties, accounting for 34% of the cases. Similarly, 30% of the participants associated poverty with child marriages, while 17% mentioned lack of access to education as the cause of child marriage.

3.5.8 Gender-based Violence

The prevalence of multiple types of violence against children, both within and outside Kenyan schools, continues to be a major concern in Kenya. According to the survey, Sexual violence and rape is prevalent in Busia County (37%), Turkana (36%), Homabay 32%, Bungoma (32%), Siaya (31%), Nakuru County (18%), Meru (12%), Nairobi (9%), and Machakos Counties (7%) and it is commonly attributed to teenage pregnancies. The findings are aligned with the 2019 Kenya Violence Against Children Survey (VACS) that found that 49 percent of girls and 48 percent of boys aged 13–17 years had experienced physical violence, and 11 percent of girls and 4 percent of boys indicated that they had experienced sexual violence. The survey further established cases of forceful sexual encounters (rape) leading to teen pregnancies. From the qualitative data, there were twenty-one (n=21) citations of force, rape, or violence. 21 cases/citations out of 205 open-ended citations/reasons translated to **10.2%** cases of rapes, defilements, or SGBV associated with teenage pregnancies.

During the FGD, over 60% of SGBV cases occurred at the boyfriends' homes. Similarly, several incidences, estimated at 20%, occurred at relatives' homes (grandmother's, auntie's, and uncle's places), and another 10% happened elsewhere in the forest, shamba, and on the wayside. Few cases occurred in guest houses and lodges. The other 10% happened in different places and with different people, like policemen, herders, strangers, and parents.

3.5.9. Poverty

Poverty was also associated with the high prevalence of teenage pregnancy in the host community**.** 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.[20]. According to the survey, poverty was ranked as the top contributor to teenage pregnancy; hence, tackling it or having strategies addressing it could significantly reduce teenage pregnancies. In Nyanza and Western counties, poverty was ranked highest as the cause of teenage pregnancy (30%). On the other hand, poverty was ranked third across the three counties, Kajiado and Turkana, at 19%, and 17% in Narok as the main cause of teenage pregnancy. In Muranga, Nyeri, Nyandarua, Meru, Kiambu, and Nakuru counties, poverty contributed to 49% of teenage pregnancy in the six counties. Similarly, 30% of the participants associated poverty with teenage pregnancy in Nairobi, Machakos, *and Garissa Counties.*

Focus group discussion respondents indicated that many parents are unemployed. They are without jobs and income. Hence, they cannot afford to buy the necessary items required by girls in schools. When girls lack pads and

[20] CSA (2008): Down the Drain: Counting the Costs of Teenage Pregnancy and School Drop out in Kenya

other essentials such as oil, and parents are unable to provide them, they look for sex in exchange for essential items. A girl in Homa Bay shared:

> *"Wasichana wengine wanakuwanga na parent mmoja utapata ameishi na parent mbaba yake akona mahitaji yenye anataka na haezi ambia baba yake, so unaeza pata anatafuta mtu mwenye aneaza kumununulia Hizo vitu anaenda kumuomba na huyu mtu haezi mpea tu lazima atamlipa na inalead to mimba ."(Other girls have single parents, and if the girl has needs to be met, she will get someone, mostly a man, to buy the things, and then she will pay in kind or by transaction sex, which could lead to other unwanted pregnancies."*

In other areas, such as Kakuma, the common practice is for poor parents to send girls to refugee camps to work and earn income for households. Many of the girls who work in the refugee camps are susceptible to sexual abuse by rich refugees. They are paid extra money for sex, and whenever they refuse sex for money, they are raped.

During the discussion, most of the Key informants also indicated that household poverty due to the death of one or both parents had been responsible for pregnancies in the area. A girl from Nairobi County said:

> *"Let me use myself as an example. What led me to have a child in my teen years was that my mother was the breadwinner, and she passed away while we were still in school, and we were left with our older sister. When she completed her form four, she moved out and married so I was left to provide for my younger siblings. This forced me to look for a boyfriend to support me, and through that, we had sex, and I conceived. The child died, then we got another one."* ***17-year-old teenage mother, Nairobi FGD, Nairobi County.***

During the FGD, other participants indicated that the living conditions, especially in the informal settlement, have also contributed to teenage pregnancy. A civil servant with experience working in the informal settlement said:

> *"Poverty is the major contributor to teenage pregnancies. For example, a family living together in a single room. Teenage girls learn these things from their parents and practice them with their boyfriends. The result is teenage pregnancies."* ***Police officer, Nakuru Town, Nakuru County***

3.5.10 Drug and substance abuse.

Findings of the study through FGDs members shows that drugs and substance use are known to lead to irresponsible and risky sexual behavior as they affect judgment and decision-making. Most girls who engage in drug abuse are unable to assert themselves, especially when it comes to saying no to unprotected sex, thus resulting in exposure to sexually transmitted infections and/or unplanned pregnancies. According to NACADA (2017), sex resulting from the influence of alcohol and drug abuse is common. According to the report, 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[21]. In addition, drug use is closely tied to being truant and dropping out of school. Those using drugs are mostly likely to skip school.[22]

[21] NACADA (2017): Rapid Situation Assessment of Drugs and Substance Abuse in Kenya
[22] Chesang, R.K. (2013): Drug and Substance Abuse among Youth in Kenya (International Journal of Scientific and Technology Research; Vol. 2 Issue 6)

3.6 REPORTING OF TEENAGE PREGNANCY

Across the twenty counties, it was reported that the first person to be informed about teenage pregnancy was the parent (mentioned by 70% of the teenagers). Another 34% of the teenagers also preferred reporting their cases to teachers and 26% to relatives. Social workers were least reported to (9%) whenever teenage pregnancy cases occurred.

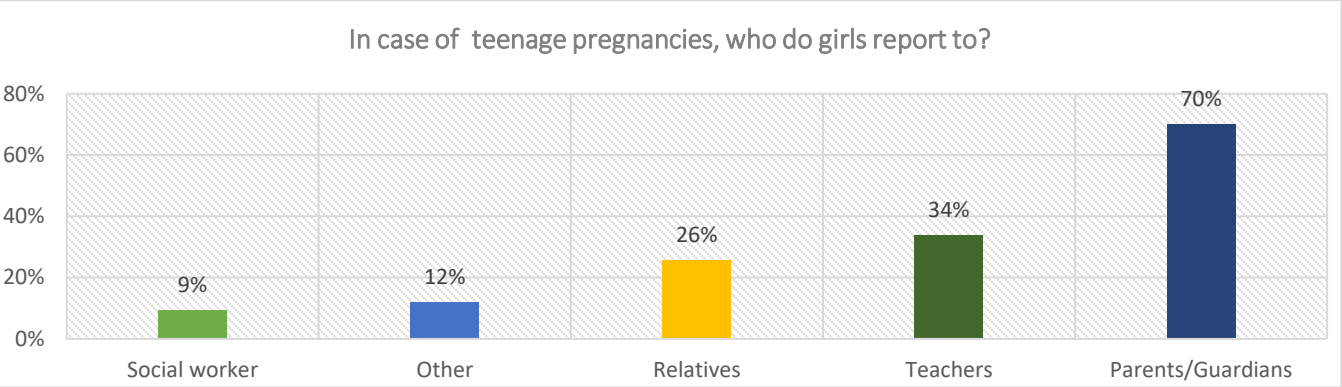


Figure 16: Where teenage pregnancies are reported

The study observed that a significant number of teenagers (57.6%) are aware of individuals to whom cases of child marriages can be reported. Among those mentioned were the chief and police (41%), village elders (24%), and county social offices (18%). Teachers were also mentioned by 13% of the respondents as possible people to be reported to in cases of child marriages, as shown below.

The following were the individuals where teenage mothers can report child marriages.

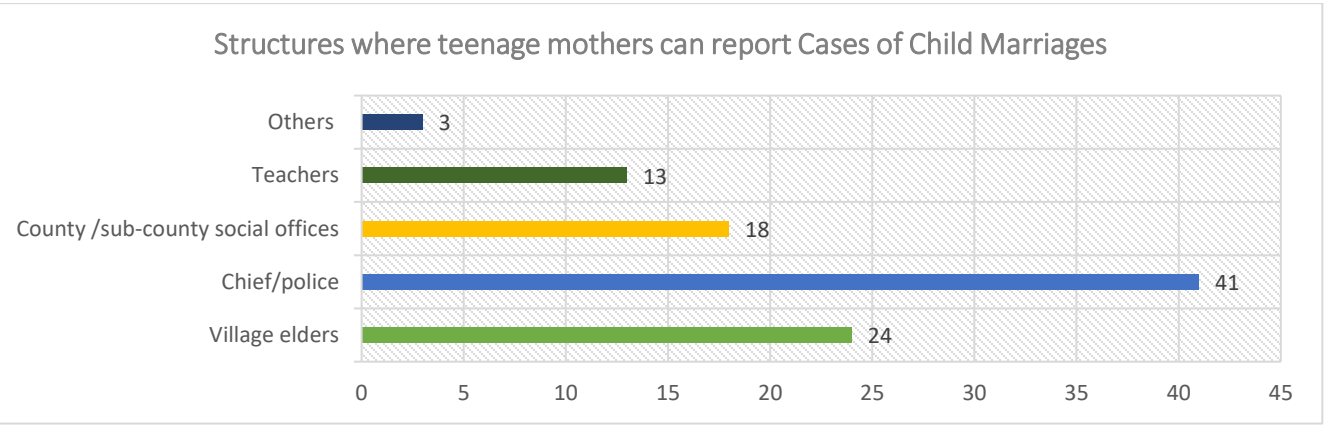


Figure 17: Structures available for reporting cases of child marriages

In terms of reporting structures, participants indicated their awareness. The awareness of reporting structures was highest in Nyeri (61%), Nairobi (60%), Meru (60%) and Elgeyo Marakwet (53%). However, awareness of reporting structures was lowest in Garissa (74%), Migori (71%), Kajiado (70%), Kakamega (67%), Turkana (67%), Narok (69%), and Homabay (66%) as shown on the Figure.

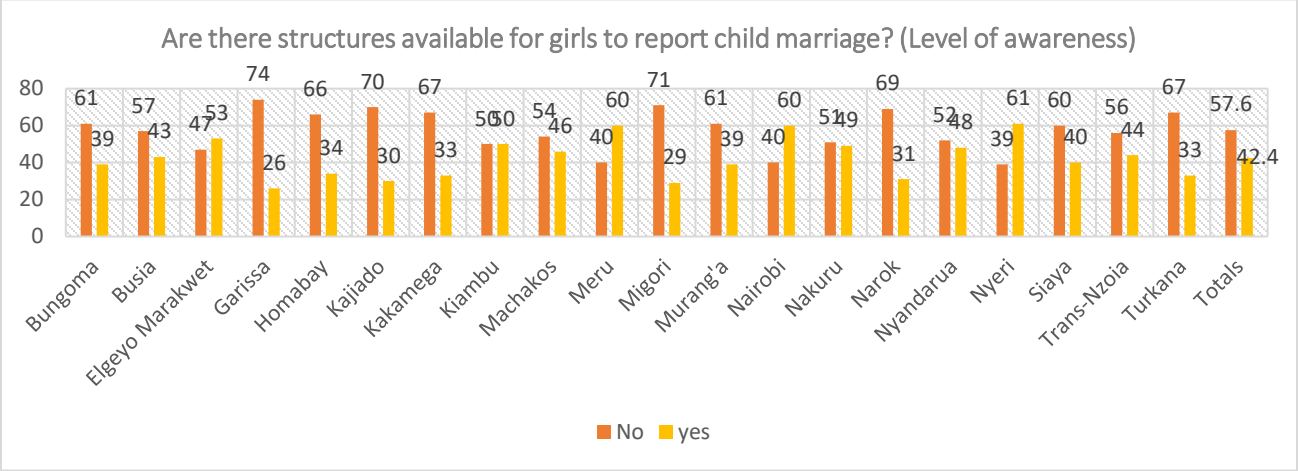


Figure 18: Level of awareness on structures where teenage mothers can report child marriage to

Learners knew about reporting structures, and many of them attributed awareness to the work of NGOs, government officers, and community leaders. Some of the participants attributed the knowledge on reporting structures to teachers and religious teachings which inform them in forums like youth camps.

Negative effects of child marriage mentioned by the participants included dropping out of school (80%), increased poverty (56%), risk of abuse (55%), poor health (46%), and missing out on teenage life (38%). From the qualitative data.

3.7 EFFECTS OF TEENAGE PREGNANCIES ON GIRLS

About **69% % of the girls indicated that they are aware of the effects of teenage pregnancies** on education and their future. However, awareness varied from county to county, with Kakamega registering the highest awareness (88%), followed by Migori (83%) and Nairobi (81%), as shown.

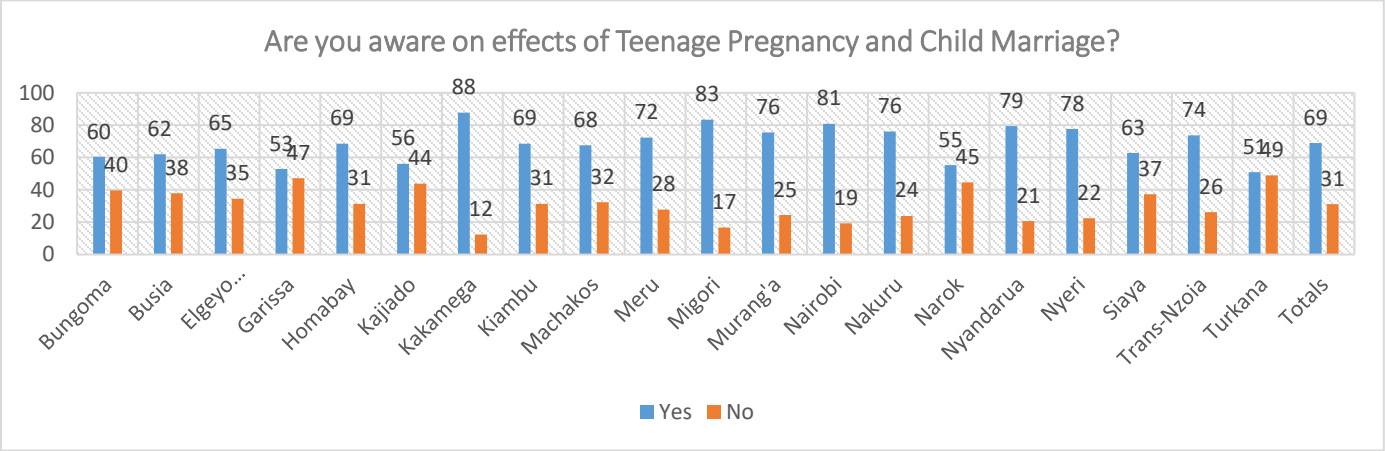


Figure 19: Aware on effects of Teenage Pregnancy and Child Marriage

However, 31% of the girls were not aware of the effects of both teenage pregnancies. The lowest awareness was registered in Turkana (49%), followed by Garissa (47%), Narok (45%), Bungoma (40%), Busia (38%), and Siaya (37%). Further, that creates a need for program interventions on awareness of the effects of teenage pregnancies on the well-being of adolescent girls.

3.7.1 Effects of Teenage Pregnancies on the school-going girls

The study established that pregnant and parenting teenagers face several adversities, such as **social stigma, lack of emotional support, poor access to healthcare, and stresses** around new life adjustments.[23] The girls interviewed indicated rejection (61%), a leading effect of teenage pregnancy. Most girls report facing rejection from their parents, friends, and schoolmates. The second most mentioned effect was dropping out of school (56%). Depression was the third top effect at 52%, and this included mental illness at 25%, implying the effects of teenage pregnancies on the mental health of teenage girls. Other effects were STI/Ds at 50%, premature births at 38%, and others.

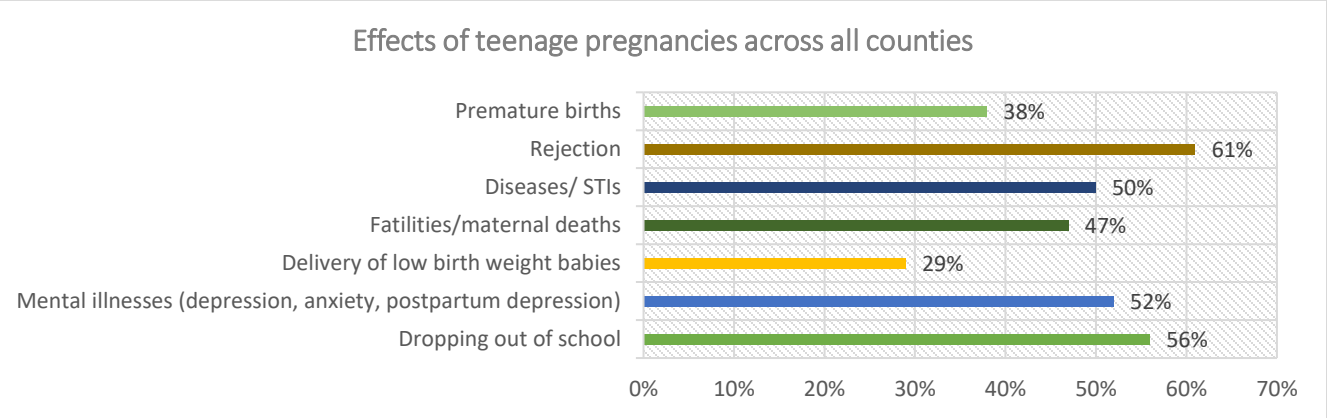


Figure 20: Effects of teenage pregnancies

A child Protection officer gave a summary of the effects of teenage pregnancy. He said:

> *'The consequence of teenage pregnancies includes school dropout, girls being sent away from home to stay with the person responsible for the pregnancy, and at times they have suicidal ideation, some are killed to hide any evidence of physical abuse they go through, and some die while giving birth."* ***Child Protection Officer, Homabay County****.*

The consequences of teenage pregnancy were grouped into psychological, health, social, and economic consequences. Teenage mothers are often psychologically ridiculed or stigmatized by their parents and community members. They indicated isolation, loneliness, stress, and depression as common lived experiences around teenage pregnancy. The lack of support from their male partner and/or boyfriend added more pressure and accelerated feelings of despair and sadness. They are treated like adults and are expected to be responsible for themselves. This has resulted in some of them dropping out of school to fend for themselves.

Other girls have been forced to get married or run away from home when their family rejects them. These challenges further lead to psychological problems such as depression, low self-esteem, disturbing memories about some difficult pregnancy experiences, feeling lonely, feeling like a failure, mood swings, suicidal thoughts and attempts, and changes in the body. The teenage mothers further reported health challenges such as fistula, STIs, complications from abortion, bleeding, miscarriages, and loss of appetite.

[23] Kumar, M., Huang, K. Y., Othieno, C., Wamalwa, D., Madeghe, B., Osok, J., Kahonge, S. N., Nato, J., & McKay, M. M. (2018). Adolescent Pregnancy and Challenges in Kenyan Context: Perspectives from Multiple Community Stakeholders. *Global social welfare : research, policy & practice*, *5*(1), 11–27. https://doi.org/10.1007/s40609-017-0102-8

Their performance is negatively affected at school due to inadequate attendance, added responsibility, and poor concentration in class. Some drop out of school to take care of the baby, and this, they reported, crashes their life goals and dreams. One of the teenage girls interviewed reported,

> *"I regretted I didn't manage to reach my future goals and dreams of being a nurse."* ***17-year-old in Narok County***

Teenage mothers also tend to take longer in school than their age mates, which makes them feel left behind.

3.7.2 Support to Pregnant and Teenage Mothers

Regarding support given to girls who experience teenage pregnancies and child marriages, most of the participants (74%) indicated that **they were not supported**, while only 26% said they **were supported during the pre and postnatal period.** Another 59% of adolescent girls interviewed indicated that support came from NGOs, while others (51%) got support from the government. Further, 28% got support from the CBOs, with 33% indicating that they received support from individual members of the community.

School re-entry came out as one of the most mentioned forms of support (60%). Re-entry allowed teenage mothers to continue with their education. While at school, the teenage mother indicated that they were allowed to go for medical checkups, and were allowed a flexible schedule, where they could leave school earlier than the rest. In some schools, they were given a special diet, excluded from manual work, and provided with counseling services. The special treatment they received in school, according to FGDs and key informants, created a perception that getting pregnant could lead to special treatment in school. Other forms of support included medical care and health talks (45%), guidance and counseling (30%), financial/material support (20%) from parents for some of the girls, and support from NGOs with sanitary pads (15%).

The constitution of Kenya is strongly linked to ensuring teenage girls (as well as boys) get equal opportunities to education. The constitution therefore allows any learner, whether teenage mother to be readmitted to school to pursue her education and life goals. Perpetrators of teenage pregnancies, as well as need to be met with necessary punishment for impregnating schoolgirls. In case of the regions with security threats, the ministry of Education in conjunction with necessary government agencies need to ensure safety of learners to reduce absenteeism which increases likelihood of teenage girls getting impregnated.

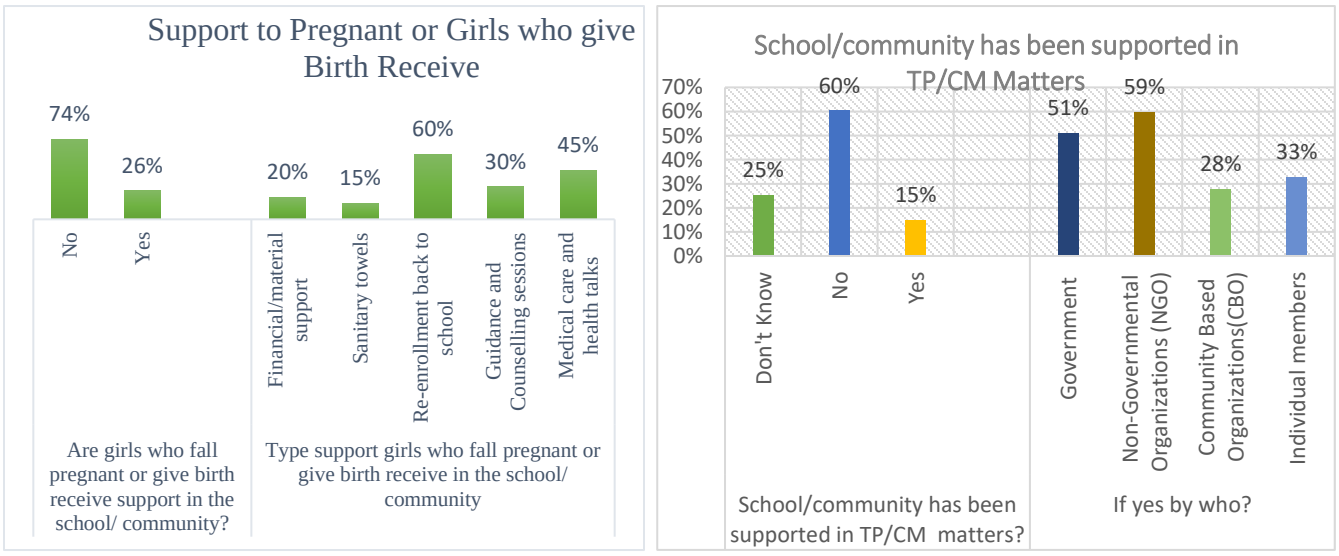


Figure 21: Support to pregnant girls or young mothers and form of school support

3.8. LAWS, POLICIES, AND INSTRUMENTS RELATING TO PREVENTION OF TEENAGE PREGNANCIES IN KENYA

This section presents a review and brief analysis of the laws, policies, and ordinances that protect teenage and young girls from teenage pregnancy. Similarly, a triangulation of the primary data was done to ascertain the levels of awareness and knowledge of the participants' laws and policies on teenage pregnancies. Some of the legislations related to the protection of learners include the Constitution of Kenya 2020, the Basic Education Act, the School Re-Entry Guidelines (2020), the National School Health Policy (2018), and Kenya's 2015 Adolescent Sexual and Reproductive Health.

3.8.1 The Constitution of Kenya and Legislation

Every child in Kenya has a right to free and compulsory basic education, according to Article 53(1) (b) of the constitution. The Kenyan Government implemented free primary education to enable all children to access basic education, regardless of their financial situation. Many children, especially those from poor backgrounds, have benefitted from it. However, there have been challenges faced in the strife to achieve this agenda, some of which may include, but are not limited to:

i) *Insecurity and terrorism in Northern Kenya*; Such challenges have made it impossible for many children to enroll in learning institutions due to fear of terrorist attacks. Additionally, in these regions, there is high teacher turnover and teacher absenteeism associated with insecurities and terror attacks. Many teachers do not want to be deployed in these regions because of the risks associated with the areas. Insecurity has consistently led to school closures especially in ASAL areas and during these closures' girls become susceptible to pregnancy leading to further school dropouts.

It is the government's responsibility to ensure security for its citizens. Both learners and teachers need assurance of security to deliver their learning and teaching mandates. Ensuring an enabling environment for both the learners and teachers would help teenage girls achieve a compulsory basic education.

ii) *Insufficient funds*; lack of enough financial allocation to the Ministry of Education to cater for tuition fees has been a major challenge in achieving free primary education as envisioned in Article 53(1) (b) of the constitution. Schools need funds to run, which has increased school administrations' aggressiveness in collecting school, making some learners, especially those from poor family backgrounds, remain at home. Teenage girls who fall victim to staying home due to lack of school fees are prone to child marriage and consequent teenage pregnancies.

The government ought to allocate enough funds to the education sector and disburse the funds as early as possible to ensure that no learner misses school due to a lack of fees.

3.8.2 Basic Education Act (Act No. 14 of 2013, last amended in 2017)

This Act provides the first time in Kenya that all children with disabilities have the right to free and mandatory education. However, the Act keeps Kenyan children with disabilities a target of prejudice. This is evidenced by the fact that:

i) Without any explanation, the Act establishes special schools for children with disabilities- children with and without disabilities should be treated equally, which entails giving all learners the same treatment while giving some children alternative treatment based on their need for modifications. The law discriminates against children with disabilities by failing to make reasonable accommodations for them in the classroom with other non-disabled learners. Although some children with impairments might require help or accommodation, that is not always the case. Therefore, there is no reason to treat children without impairments any differently from those who are abled

differently. By isolating children with special needs, they expose them to higher risks of dropping out of school, hence increasing exposure to teenage pregnancy.

ii) Again, the law does not guarantee an inclusive educational system, as required by the United Nations Convention on Rights of Persons with Disability (CRPD) article 24. As mandated by the CRPD, this law does not go far enough in promoting equitable educational opportunities for children with disabilities. We contend that it is instantly feasible to guarantee, at the very least, that children with disabilities have the right to an education in a setting with the fewest restrictions.

Further, the Basic Education Amendment Act (of 2017) mandates the Government of Kenya through the Ministry of Public Service, Youth, and Gender Affairs to support school-going teenage girls with free, sufficient, and quality sanitary towels. The challenge has been shifting the allocation of the mandate to different ministries or departments and the lack of financial allocations to provide free and quality sanitary towels to school-going teenagers and young girls.

3.8.3 The National Guidelines for School Re-entry in Early Learning and Basic Education -2020

The National Guidelines for School Re-entry in Early Learning and Basic Education (of 2020) states that pregnant girls who leave school should be readmitted six months after delivery, allowing the teen mother to nurse the baby. This strategy aims to help prevent young mothers from being excluded from the basic right to education. The policy targets long-term poverty reduction through promoting girls' education and aids in the growth of the nation. This policy has not been well embraced as little awareness and sensitization exists. Because of the perception to limit exposure of other non-pregnant students and maintain the reputation of the schools, Kenyan teachers have openly disobeyed or neglected to enforce this guideline.

The economic status of families of teen mothers is another factor negatively affecting the adoption of this policy. Chances are minimal for teen mothers, especially those from poor backgrounds, to re-enroll. They are instead forced to fend for themselves, their children, and, in some cases, the whole family.

One of the recommended actions towards strengthening this policy is for the Ministry of Education to increase the intensity of awareness, especially among education stakeholders, including head teachers, teachers, learners, and parents. Strict implementation and adherence to the policy by the MoE and her agencies is recommended, with teachers who flout it (by failing to re-enroll these girls) in the name of maintaining the school's reputation getting punished. Teachers, along with local government administration (chiefs/sub-chiefs and village administrators), need to follow up on those girls who have dropped out of school due to pregnancy or childbirth.

Awareness and Re-entry to School of Teenage Mothers

The awareness of the existence of laws and policies that support re-entry cross-tabulated per county. Narok (32%), Nyeri (23%), Machakos (20%), Elgeyo Marakwet (19%), and Bungoma (16%) had the highest proportions of students aware of the existence of re-entry policy in Kenya, as shown below. However, Kakamega (2%), Meru (4%), and Turkana (4%) had the lowest knowledge levels of the existence of any ordinances or policies that support back-to-school for girls who had dropped out of school. Surprisingly, counties such as Muranga and Nyandarua had no participants with knowledge of the re-entry policy,

Table 7: Awareness on re-entry guidelines for girls who drop out of school

County	No	Yes
Bungoma	84%	16%
Busia	94%	6%

Elgeyo Marakwet	81%	19%
Garissa	94%	6%
Homabay	87%	13%
Kajiado	96%	4%
Kakamega	98%	2%
Kiambu	96%	4%
Machakos	80%	20%
Meru	96%	4%
Migori	82%	18%
Muranga	100%	0%
Nairobi	85%	15%
Nakuru	95%	5%
Narok	68%	32%
Nyandarua	100%	0%
Nyeri	77%	23%
Siaya	90%	10%
Trans Nzoia	88%	12%
Turkana	96%	4%
Total	**89%**	**11%**

The direct impact of the low knowledge levels is that affected teenage girls are not able to demand their rights back to school, hence school dropout. Surprisingly, the survey confirmed that teenage mothers in Turkana (49%), Narok (45%), Siaya (37%), Kajiado (44%), Busia (41%), Bungoma (40%), and Garissa (35%) are unlikely to return to school after giving birth because they get married.

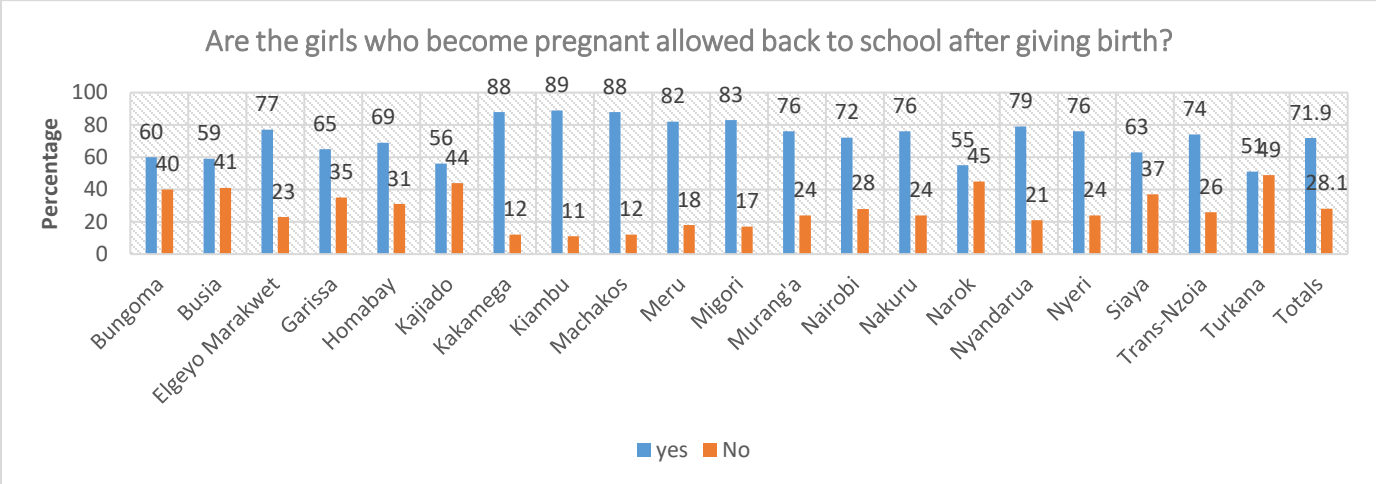


Figure 22: Level of awareness among respondents on re-entry back to school

The 28.1% of teenage mothers not going back to school sounds an alarm as this compromises the future of their lives. This translates to over 28.1% of the school going learners dropping out of the education system, compromising their future livelihoods, and promoting illiteracy. The high rate of teenage mothers not returning to school exposes the community to lost opportunities for employment and an earning of livelihood.

3.8.4 National School Health Policy (2018)

The National School Health Policy (2018) in Kenya addresses critical aspects of health and well-being for school-going children, with particular emphasis on teenage pregnancies and child marriage. To prevent teenage pregnancies, the policy underscores the importance of comprehensive sexuality education (CSE) in schools, ensuring that students receive accurate information about reproductive health, contraception, and the consequences of early sexual activity. This education empowers adolescents to make informed decisions and reduce the incidences of teenage pregnancies. The policy further advocates for improved access to adolescent-friendly reproductive health services, including counselling and family planning, to provide teenagers with safe and confidential options to prevent unintended pregnancies. The policy also calls for supportive environments for pregnant students, discouraging stigmatization and discrimination and urging schools to provide necessary support, including counselling, so that these girls can continue their education even after giving birth.

In addition to addressing teenage pregnancies, the policy also focuses on preventing child marriage, which often leads to early school dropouts and perpetuates cycles of poverty and health risks. It emphasizes the enforcement of existing laws that set the minimum age for marriage, advocating for the protection of children from harmful practices. It highlights the importance of community engagement, recognizing that changing cultural and societal attitudes toward child marriage is crucial. It further calls for community-based awareness programs that advocate for the rights and education of girls. To effectively combat child marriage, the policy promotes collaboration between schools, government agencies, non-governmental organizations, and other stakeholders to develop and implement interventions that safeguard the education and well-being of at-risk children.
The National School Health Policy (2018) in Kenya prioritizes preventive education, access to health services, support for pregnant adolescents, protection from child marriage, community engagement, and multi-sectoral collaboration to address teenage pregnancies and child marriages comprehensively.

3.8.5 Kenya's 2015 Adolescent Sexual and Reproductive Health

The policy was launched in 2015 to reiterate the commitment to ensuring adolescents have access to thorough SRH knowledge and resources. A few factors, such as giving school-going teenagers priority and creating an environment that encourages collaboration on adolescent health concerns, helped make adolescent human sexuality services more accessible.

However, the policy has not been well achieved due to several challenges, including Health care providers' unfavorable views, travel time to the facilities due to the long distances involved, high service costs, preservative social and cultural pressures, and a lack of secrecy and anonymity among the ASRH service seekers.

3.8.6 Kenya Menstrual Hygiene Management Policy (2019-2030)

This is a milestone policy in Kenya's strides towards universal access to improved sanitation and hygiene on menstruation.[24] Kenya made a significant first in the fight to ensure menstrual hygiene (MH) when it became the first country in 2019 to design and develop a stand-alone comprehensive MH policy. This policy seeks "to ensure that all women and girls in Kenya can manage menstruation hygienically, freely, with dignity without stigma or taboos, and with access to: the right information on MHM; menstrual products, services, and facilities; and to dispose of menstrual waste safely." The Kenya MH policy ought to be implemented by the Ministry of Health (coordinating, supervising, and supporting its implementation). Further, it collaborates and synergizes with other policies, such as the Adolescent Sexual and Reproductive Health Policy and Reproductive Health Policy 2020-2030.

[24] https://menstrualhygieneday.org/wp-content/uploads/2022/06/MHH_Kenya-Snapshot-v2_2022.pdf

The policy is directly linked to menstrual hygiene, where schoolgirls need to be supported with menstrual products to maintain them in schools. Failure to effectively implement this policy exposes the schoolgirls to risks of engaging in risky behaviors exposing them to teenage pregnancies.

One of the shortcomings of the Kenya MHM Policy (2019-2030) is that there are limited or no budgetary allocations to support its implementation across over 10 ministries and departments that are mandated with policy implementation. Similarly, while this policy has been in existence, less of it has been implemented to achieve its mission to ensure that girls and all women can manage menstruation freely, hygienically, and with dignity without stigma and any taboo. The policy also strives to achieve access to the right information on menstrual hygiene management, menstrual products, services, and facilities, as well as the safe disposal of menstrual waste. The implementation of Kenya's menstrual hygiene management policy is silent.

Table 8: Summary of International and Local legislations on protection of learners

International Laws and Policies	Local legislations and policies
SDG goal no 4 (on education)	The Children Act, 2022
Interagency GBV Case Management Guidelines, 2017	Medium Term plan, 2018-2022
Global Guidance in addressing School Related Gender Based Violence, UNESCO, UNWOMEN, 2016	Education and Training Sector Gender Policy 2015
Inter- Agency Guidelines for case management & child protection,2014	The Criminal Procedure Code (Revised Edition 2012)
Communities Care Programme: Transforming Lives and Preventing Violence, UNICEF, 2014	National Gender and Development Policy, 2011
Caring for Child Survivors of Sexual Abuse UNICEF/IRC, 2012	The Kenya Children Policy, 2010
IASC guidelines on Mental Health and Psychosocial Support, 2008	National Guidelines for Management of Sexual Violence in Kenya, 2009
Guidelines for Gender-Based Violence Interventions in Humanitarian Settings, IASC, 2005	The Education Gender Policy, 2007
Clinical Management of Rape Survivors, WHO/UNHCR, 2004	The Sexual Offences Act, 2006
United Nations Declaration on the Elimination of Violence Against Women, 1993	Guiding and counselling policy
African Charter on the Rights and Welfare of the Child ,1990	Mentorship policy for Early Learning and Basic Education
United Nations Convention of the Rights of the Child, 1989	
The Convention on the Elimination of Discrimination Against Women, 1979	
GBV Information Management System User Guide	

3.8.7 International Legislation and Laws

a) UN Convention on the Rights of the Child

Every child ought to be recognized, valued, and safeguarded as a person with rights and as a special and valuable member of society, and this principle is embodied in the UNCRC. All individuals below the legal age limit of 18 are affected. Children have the right to a high quality of living and to good health, education, home life, play, and leisure. They also have the right to be safe from violence and abuse. The lives of many children have changed significantly since the UNCRC was adopted in numerous ways.

There have been challenges in the protection of child rights due to varying socioeconomic and political circumstances, such as societal changes in the household unit, poverty, and increasing cost of living. In much of Africa and Kenya particularly, the spread of HIV/AIDS, civil strife, and warfare pose a significant obstacle to the preservation of children's rights.

In Kenya, most children continue to be exposed to dangerous behaviors, parental neglect, sexual assault, and physical and mental abuse. Children are also more vulnerable during and after crises like floods, droughts, wars, or diseases. In the Kenyan scenario, many of the northern counties face such crises, with school-going children missing school due to droughts, cattle rustling, and insecurity.

The UN Convention on the rights of child is the supreme international law that guides on child protection, hence its application in this situational analysis on teenage pregnancies. Further, the UN convention on the rights of the child protects teenagers by ensuring that they get access to good education, health, home life and other rights, irrespective of their situation. The UN convention guides on protection of teenagers as well as other children in ensuring they get access to education and good health.

b) AU African Charter on the Rights and Welfare of the Child

The African Nations are required under the Charter to safeguard children from every kind of harm, bias, abandonment, and exploitation. Additionally, it affirms that children have a right to exercise their freedom of speech, association, opinion, faith, and moral conscience. The charter is significant because it has acknowledged the child's distinctive position in African society, where they (children) have privileges, including special protection and access to education.

The "claw-back" clauses of the African Charter are arguably its biggest shortcomings. For instance, the clause that permits a state to restrict its treaty obligations and/or the rights guaranteed under the African charter. The charter does not have a derogation clause that allows country to temporary abstain from their obligation under the treaty in emergency situations. Secondly, in most African countries national law has primacy, therefore human rights can be limited or even violated despite being protected by the Charter. This makes its application limited in application as it is not given primacy in its application. The charter guides countries in guaranteeing the rights and welfare of the child. These provisions are included throughout the African Charter and empower African states to grant fundamental human rights to the fullest extent permitted by domestic law.

The AU African charter focuses on rights of children hence it protects schoolgirls. The charter is strongly linked to the study as it focuses on safeguarding African child from home, abandonment and exploitation. School girls falling pregnant are likely to be abandoned and drop out of school, and they experience different forms of harm; mental, and physical.

3.8.7 Awareness of Laws and Policies by Learners

There were significant gaps in the level of awareness and knowledge of laws and policies on teenage pregnancies, as established from primary data. It was established that only 6% of the teenage respondents were aware of some laws on reproductive health rights, while the majority, 94%, were not, as shown below.

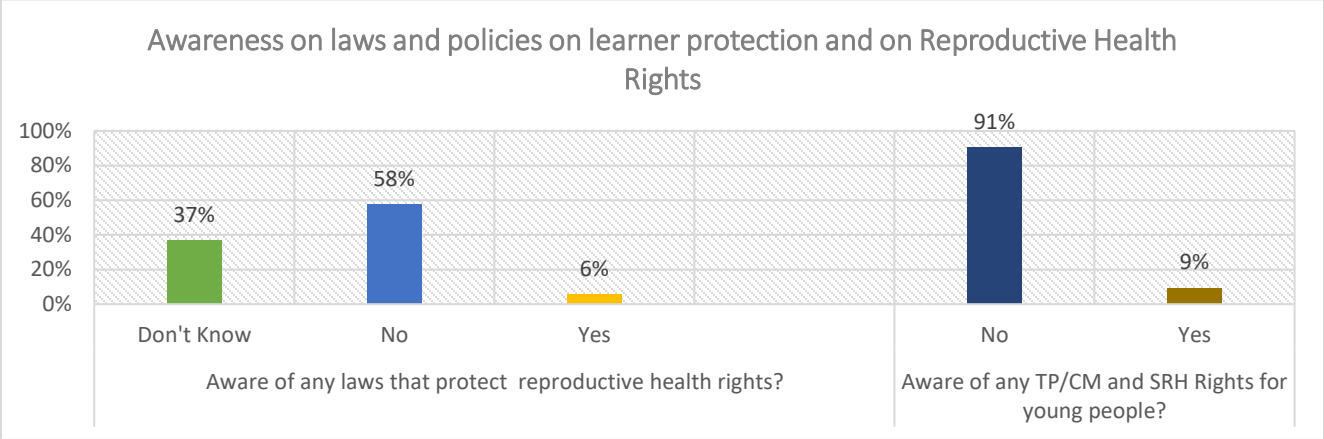


Figure 23:Awareness on laws and policies on learner protection and on Reproductive Health Rights

This shows a gap that needs to be explored by targeting learners in schools and informing them of the basic laws and human rights to enhance their protection. The findings further expose a gap in knowledge on laws that deal with reproductive health rights and that touch on TP

3.9 BEST PRACTICES IN REDUCING GIRLS' EXPOSURE TO TEENAGE PREGNANCIES

This section presents the best practices as drawn from the primary data and secondary literature review on how best to reduce girls' exposure to teenage pregnancies and child marriage.

3.9.1. Age-appropriate family-life education:

Age -appropriate family life education is one of the key components in a multifaceted approach to address the high need for age-appropriate family-life information and services among adolescents. Many of the interviewees believe that family-life education is more than the instruction of children and adolescents on anatomy and the physiology of biological sex and reproduction. Both boys and girls need to be taught on age-appropriate family-life education which covers healthy sexual development, interpersonal relationships, affection, sexual development, intimacy, and body image for all adolescents, including adolescents with disabilities, chronic health conditions, and other special needs. The Education Administrator stressed the importance of educating girls on the dangers of teenage pregnancy. One of the education administrators noted,

> *"By educating them on the consequences of teenage pregnancy, they can make informed decisions."* ***Education administrator, Garissa County***

3.9.2 Provision of Adolescent Youth-friendly services (AYFS):

Youth-friendly services are meant to help young people overcome barriers to accessing quality counselling and information on family-life issues. Adolescent youth friendly service centers can eliminate their fears, respect their concerns and confidentiality, and provide services within an environment that suits their preferences. Some of the strategies that have successfully been used are:

(a) **Community-based:** Services and information that is offered to adolescents and youth within the community/non-medical settings e.g. in youth centers, outreaches, religious centers, youth groups, community-based groups, support groups, peer-mentorship

(b) **School-based:** Services and information are offered to adolescents and youth within the school setup.

(c)Clinic-based services and information are offered to adolescents and youth within/based on the 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 centers that have clinics within their setting and can adopt a clinical-based model.

(d) Virtual-based Services and information offered to adolescents and youth within the virtual space or digital platforms, e.g., eHealth, mHealth, telemedicine, and warm/ hotlines.

3.9.3 Engaging Boys and Men in the Teenage Pregnancy Prevention Programs: men and boys have been mentioned as the perpetrators of teenage pregnancies, as established in this study. By engaging the boys and men as a means of support to the girls, then teenage pregnancies would be reduced significantly. A civil servant in Nakuru said:

> *"… but moving forward, we are embracing the boys too in programs for preventing teenage pregnancies. We cannot be implementing programs targeting the girls, and not involving the boys to support the course,"* Police officer, Nakuru County.

The engagement of boys and men would include but not be limited to training on age-appropriate family-life education, the Creation of awareness among boys and men the need to appreciate biological changes that the girls go through. Boys & men not to profile teenage girls when in their menses.

3.9.4 Enforcement of Laws and Policies: This is another important strategy for preventing teenage pregnancy. Cases of teenage pregnancy are reported to the police or child protection organizations, and those perpetrators are arrested and charged or made accountable. The law should be strictly enforced, and anyone found impregnating school-going girls (those below the legal age of 18 years) should face the law. The interviewees agreed that these measures are important steps in preventing teenage pregnancy and sending a strong message to the community that such acts are unacceptable and ought not to be tolerated.

3.9.5 Promotion of School Clubs

FAWE-K has initiated peer-to-peer conversation forums, in form of Tuseme Clubs. The school clubs are intended to provide a platform to facilitate a discussion on youth and adolescent issues affecting learners. The survey also sought to understand whether the respondents were engaged in any clubs responsible for educating and sharing age-appropriate family-life education. About 10% of the participants were members of school clubs, indicating that the Tuseme clubs have not been fully established in the schools. This showed that there was a need to engage both primary and secondary school learners in forming and participating in clubs that help share and communicate age-appropriate family-life education.

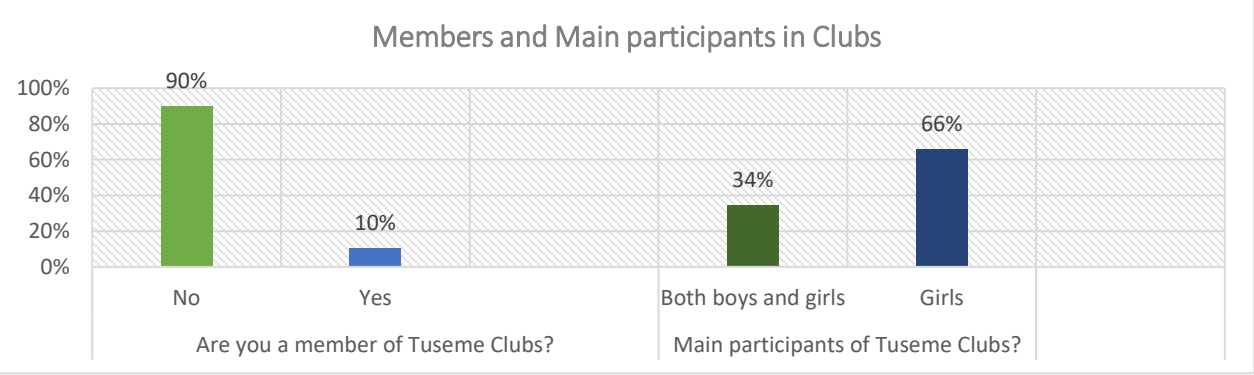


Figure 24: Members and Main participants in Clubs

Among those who were members of school clubs, girls formed 66% and boys 34% of the membership. This indicated that there is need to engage boys as well as girls in addressing issues with family-life education. This knowledge would make boys respect girls and be ambassadors of change. At the county level, in Machakos County (21%) were in one or more clubs. This was closely followed by Kiambu (28%), Kajiado (26%) and Migori (26%). Counties where involvement in club membership was not reported included Turkana, Muranga, and Nyandarua counties, driving the need to establish a peer forum for sharing family-life education information.

Benefits of being a Member of Clubs

A significant majority (96%) of those who belonged to school clubs indicated they benefited from life skills, while another 74% benefited from information and teachings on family-life education. A further 63% and 54% benefited from women's empowerment and prevention of adolescence/teenage pregnancy information, as shown in the table.

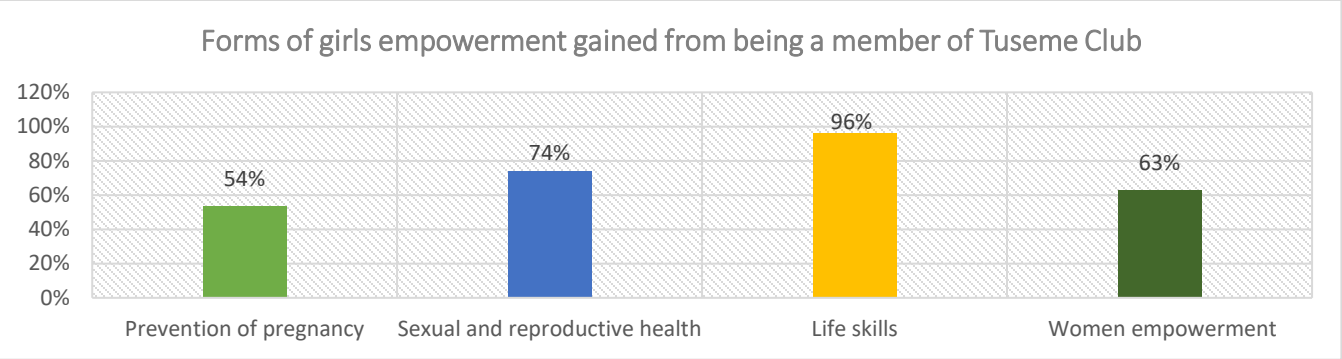


Figure 25: Form of girl's empowerment from school club memberships

Most of the participants interviewed (81%) indicated their willingness to belong to a school club in their school, with only 19% who were not interested. This is an indication that teenagers and young girls know the benefits of the school club, but there may be limited opportunities or influencers. It is therefore encouraged that forming peer-to-peer clubs in schools can enhance the sharing of information and life skills among girls

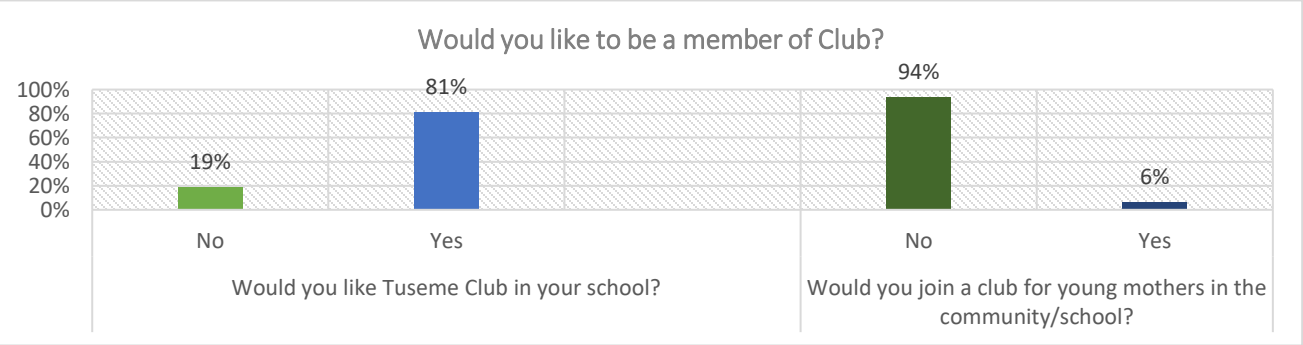


Figure 26: Likelihood of joining school clubs

It was also observed that having a young mothers club in the school and community was not popular, as only 6% supported it. Some felt that it was discriminating to have a club for young mothers, while others were of the view that having a mother's club would encourage other young girls to become pregnant so that they could join the club. In the counties with high teenage pregnancies like Turkana, Narok and Kajiado, there is need to have supportive forums where teenage mothers can discuss their plight and elicit support from school administration, the community and other learners. There is need to have clubs and forums where teenage mothers can be encouraged to return to school after delivery.

3.9.6 Provision of Menstrual Products

There were 43% of the respondents who could comfortably access sanitary pads and other menstrual products. The remaining 57% of those who could not access menstrual products signifies a gap that the FAWEK and other stakeholders like NGOs and government agencies need to bridge by supplying their needs for menstrual products. The 57% of teenagers with unmet needs for menstrual products are also more exposed to factors leading to teenage pregnancies and child marriage, including dropping out of school and seeking financial aid from boyfriends. Counties that have high percentages of girls accessing sanitary towels were Kiambu (64%), Muranga (61%), Machakos (60%), Elgeyo Marakwet (53%) and Trans Nzoia (52%). The high percentage of respondents with access to sanitary pads in those counties does not signify the absence of unmet needs but shows the proportion with unmet needs is relatively smaller compared to, say, Turkana at 78%.

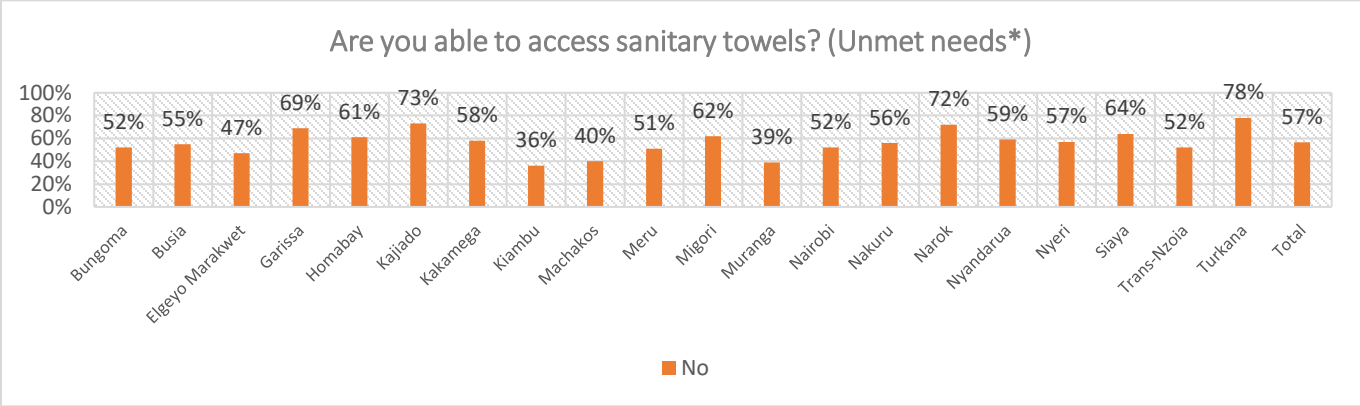
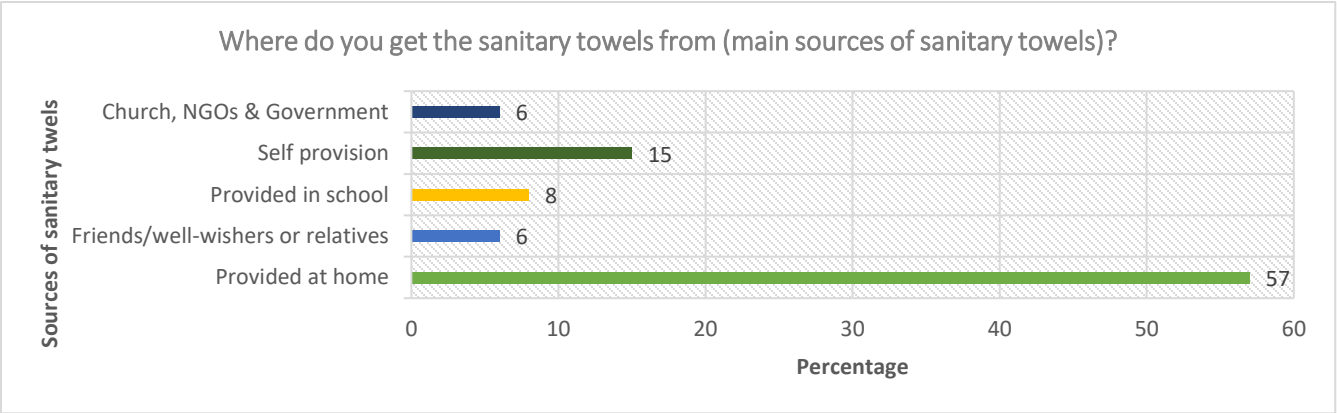


Figure 27: Unmet needs for sanitary towels

Counties with the highest unmet needs for sanitary towels included Turkana (78%), Kajiado (73%), Narok (72%), Garissa (69%) and Siaya (64%). In comparison to the secondary data from the Ministry of Health,[25] A significant majority of teenage women, 65% and 46% in urban and rural areas, have access to and use disposable sanitary towels. The report shows that over 54% of girls and women cannot afford monthly menstrual products, hence a significant gap in unmet needs. While there are policies supporting access to safe and inexpensive menstrual products in Kenya, there is a shortage in implementing the same policies.[26] For instance, the Kenya Menstrual Hygiene Management Policy (2019-2030) is a milestone policy in Kenya's strides toward universal access to improved sanitation and hygiene during menstruation.



[25] https://menstrualhygieneday.org/wp-content/uploads/2022/06/MHH_Kenya-Snapshot-v2_2022.pdf

[26] https://healtheducationresources.unesco.org/library/documents/menstrual-hygiene-management-policy-2019-2030#:~:text=The%20mission%20of%20this%20policy,safely%20dispose%20of%20menstrual%20waste.

Figure 28: Main sources of sanitary towels

For the 44% of those who indicated getting sanitary towels, over half (57%) were provided for at home, while another 15% provided for themselves. Another 8% got their menstrual products from schools as donations. From this analysis, over 43% of those who were not getting from home had potential unmet needs for sanitary towels. This could be related to uncertainties from other sources like religious centers/NGOs, schools, and friends. Similarly, the 15% who provided for themselves were also at risk of exposure to teenage pregnancies since lack of funds could expose someone to seek alternative sources of funds or means to get the menstrual products. The gap, therefore, calls for some interventions to ensure teenage girls stay in school and are not exposed to factors that can lead to teenage pregnancies.

3.9.7 Awareness and use of re-usable sanitary towels

The study further sought to identify whether the participants (teenage and young girls) were aware of the existence of reusable sanitary towels and whether they had used them. The summary of the findings is presented below.

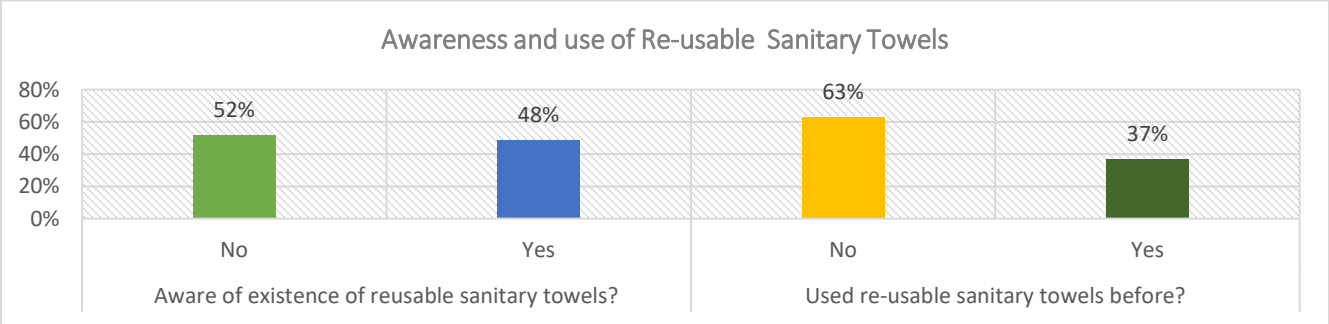


Figure 29: Awareness and use of re-usable sanitary towels

It was established that 48% of the participants were aware of the existence of reusable sanitary towels, pointing to the need to explore how the information can reach other teenagers and young girls in schools who were unaware. Since most teenagers were unaware of the existence of reusable sanitary towels, there was a need to create awareness of the existence of reusable sanitary towels. On whether those who knew had used them, about 37% of the teenage girls had accessed and used the reusable sanitary towels. The high percentage of teenagers, at 63%, who had not used reusable sanitary towels points to probable challenges in their usability, including access to water. Similarly, there were opposing views to using reusable sanitary towels. A teenager said:

> *"The re-usable sanitary towels are good. I can use one many a time. Washing and drying it in the hot sun experienced here in Kakuma makes it dry fast. In addition, when you have five or six of them, you can comfortably use and wash three in a day even if you have heavy menses."* ***Teenage mother, Kakuma, Turkana***

Various reasons have made more people who know about reusable sanitary towels embrace them. For instance, a teenage mother in Turkana felt that reusable sanitary towels were appropriate and cost-effective compared to traditional and common sanitary towels. A teenage mother said:

> *"I would use it since I am used to washing baby's clothes. For me, it is not a big deal. Furthermore, I can have as many as possible, use one, then wash and dry it."* 18-year-old teenage mother, Narok County.

Other opinions included:

"Mostly, the young girls are likely to be discouraged utilizing the re-usable sanitary towels if they fear seeing blood. The culture and habit of throwing away used sanitary pads can make them feel uncomfortable washing their blood, hence may not be popular with them," **a 16-year-old teen mother, Kakuma, Turkana**

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"Because my flow is usually heavy, I must change, wash, and air them. I will have problems using them during cold weather." **said a teenage girl from Nairobi City County.**

"I do not advise on that (re-usable sanitary towels). Because of the rate of infection, even if you wash it, it won't be up to the ideal hygiene standards. When you ask mothers about using reusable sanitary towels, they tell you it is a burden to buy them." **Nurse, Kajiado County.**

SECTION FOUR: CONCLUSION AND RECOMMENDATIONS

4.1 Introduction

The section presents the conclusion and recommendations based on primary data and findings from the literature review. The study primarily aimed to gain an understanding of the status of teenage pregnancy and Child Marriage in the Country, with a special focus on target countries ahead of program implementation. In implementing the study, the following were the key focus: (b)teenage pregnancies in Kenya, (c) Girls at risk of teenage pregnancy, and (d) the Magnitude of teenage pregnancy in selected 20 counties.[27] (e) factors leading to teenage pregnancies, (f) Effects of teenage pregnancies on girls, (g) Various national laws and policies and by-laws on handling teenage pregnancies in Kenya, and finally, (h) Best practices in reducing girls' exposure to teenage pregnancies and child marriages.

4.2 Summary and Conclusion of the Study

4.2.1 The Magnitude of Teenage Pregnancy

The study established that Kenya, and specifically counties, 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 further spiked teenage pregnancy despite strategies such as comprehensive family life education, Youth Friendly Service, and Youth clubs implemented in schools, communities, and government health centers. The teenage pregnancy rate was at 19.9%, and the top five leading counties in teenage pregnancies were Narok (43.3%), Kajiado (35.6%), Turkana (34.2%), Siaya (26.7%), Homabay (25.2%), and Meru (25%). These three counties had TP rates significantly higher than the national average (15%). The top three perpetrators of teenage pregnancies were boyfriends in school (29.1%), followed by neighbors (18.4%), and relatives (10.6%). Child marriages were common, as 17.3% of the teenagers were married. Narok, Turkana, Kajiado, Garissa, and Migori were leading with high cases of child marriage.

The survey further established that out-of-school girls, refugee girls, Asylum seekers, absentees, girls from specific geographical areas (poor rural, poor urban, and ASAL), and girls with disabilities are at risk of teenage pregnancies compared to other girls of the same age group.

4.2.2 Factors associated with Teenage Pregnancies

The five factors leading to teenage pregnancies such as drug and substance abuse, poverty, gender-based violence, child marriage, culture and traditions, lack of family-life information and services, lack of parental supervision, social media influence, and early sexual debut, are closely interlinked, and they exist both in-school and outside the school. Furthermore, the survey established that very few health facilities have the capacity to offer youth-friendly services either as standalone spaces or in an integrated manner, such that young people visit different stations to access multiple services. Further, the review established that while family-life education is integrated into the existing school curriculum, delivery is challenged by in-school and out-of-school factors, leading to a lack of knowledge and poor services.

4.2.3. Effects of Teenage Pregnancies on school-going Girls

Teenage pregnancy is a major challenge that deprives schoolgirls of the opportunity to further their education and attain their career goals. It also exposes young girls and their children to major health risks such as fistula, premature

[27] Bungoma, Busia, Elgeyo Marakwet, Garissa, Homabay, Kajiado, Kakamega, Kiambu, Machakos, Meru, Migori, Muranga, Nairobi, Nakuru, Narok, Nyandarua, Nyeri, Siaya, Trans Nzoia and Turkana

births, preeclampsia as well as vaginal bleeding, hence becoming the leading cause of death among girls aged 15–19 years. It is also a leading cause of mental health problems such as depression. The survey also established that adolescent pregnancy contributes to girls' poor performance in school and leads to social problems such as stigma and discrimination.

It was also established that most girls are not aware of support structures available for teenage girls who experience pregnancy or child marriage. Most of them rely on their families, where support is limited, and some face rejection from their families.

4.2.4. Legal and Policy Environment

The survey established commendable legal guidelines and policies that guarantee the realization of ASRH and rights in Kenya. Most notable are the Constitution, Basic Education Act, School Re-Entry guideline and National School Health Policy. The laws and policies are backed up by international instruments and the Africa Regional Charter. The existence of the relevant policy documents in Kenya confirms that there is undoubtedly a resolve to address the existing negative ASRH indicators and provides an enabling environment for doing so.

On the contrary, teenage pregnancy and other poor health outcomes continue to lag, as mentioned above. Even though Kenya has made a tremendous effort to implement a multi-sectoral approach to addressing adolescents' family-life issues, it still lacks a vibrant structure (e.g., an ASRHR technical working group) that continuously takes stock of progress and addresses emerging concerns in a timely manner. Moreover, only a few adolescents are aware of policies and laws on teenage pregnancies. Similarly, it was established that adolescent girls in some countries had no knowledge at all the existence of policies, especially on re-entry guidelines. The study also found a low level of awareness among youth regarding policies on ASRHR and rights. These findings emphasize the importance of ensuring teenage girls can access information to make informed decisions.

4.2.5 Best Practices in Reducing Girls' Exposure to Teenage Pregnancies

A combination of education, engagement, and support is key to preventing teenage pregnancy and child marriages. Preventing child marriages requires a multi-faceted approach that includes creating awareness, educating the community, and enforcing the law. Some of the best practices noted by the survey included the provision of family-life education, Provision of Adolescent Youth Friendly Services, Engagement of boys in pregnancy prevention, Law and policy enforcement, promotion of school club activities, and provision of Menstrual Hygiene products. By educating the community about the dangers of child marriages and the negative effects on young girls, the community and schools have the potential to innovate practices that eliminate teenage pregnancy.

4.3 Recommendations from the Study

4.3.1 Recommendations on Reducing Teenage Pregnancies and Child Marriages

The study recommends the following:

	Recommendation	Actor/Person responsible	Resources Needed
1.	**Parental Education:** There is a need for programs that strengthen teens' bonds with family and community. The Community, Parents and families have a far greater influence on their teens' sexual decision-making than they might think. Parents could create a conducive	Ministry of Education through school administrations at local levels; awareness at national level by MoE,	Funding for national campaigns.

	environment for children to discuss adolescent sexuality freely.	Community Health assistants, The religious leaders, chiefs	Capacity building for school administrators
2.	**Strengthening guidance and counselling in schools** to have adequate capacity to address Mental Health challenges associated with learners. Schools, in collaboration with the Ministry of Health, ought to strengthen school guidance and counselling departments, identify, train and strengthen teachers' capacity to handle matters of adolescence mental health.	MoE and line NGOs. School administrators	Funding Capacity building Age-appropriate literature for the facilitators and learners
3.	**Inclusion of boys and men in prevention of teenage pregnancies**: men and boys play significant roles in teenage pregnancies, mostly as perpetrators. They can be engaging by enlightening them on the importance of girl child education, the lost opportunities and quality of life for the schoolgirls who fall pregnant.	The Community Leaders as chiefs, Boda Boda Leaders, MoE and other NGO partners; Teachers and school administrators.	Funding Capacity building Learning materials for clubs
4.	**Provide financial assistance** through bursaries to enable young and teenage mothers from poor backgrounds to access quality education. FAWEK, MoE, and other partners must identify the needy teenage mothers who might need financial assistance to enroll back in school.	MoE & line NGOs School administrators and teachers	Funding Bursaries
5.	**Awareness of the laws and policies**: The MoE and some school administrations are aware of the re-entry guideline. While the learners are not aware, there is a need for the ministry and the school administrations to create awareness of the same among teachers and learners; and encourage learners who have dropped out of school to re-enroll.	MoE, Police, teachers, and local administration (national -chiefs/ assistant chiefs and county administration-village administrators)	Funding Capacity building Campaign & awareness materials
6.	**Law and policy enforcement at all levels**. Weak enforcement of laws related to the elimination of teenage pregnancy and child marriage. Considering that the full implementation of these laws remains a challenge, perpetrators of teenage pregnancy and child marriage often get away with these violations	Judiciary, MoE, National police service, teachers, & local administrators	Networking Funding
7.	**Engagement of male and female teachers**: Teachers spend most of the times with the schoolgirls and boys hence their interactions with them could create a positive impact. It is recommended that both female and male teachers could model and capacity-build the learners into	MoE and and Line NGOs School administrators	Capacity building Campaign & awareness materials

	acting responsibly, eliminating any form of teenage pregnancy and avoiding early sexual debut.		
8.	**Establishment of Adolescent Youth Friendly Services**: Guidance and counseling programs could be established in schools and religious centers to provide support and advice to young people on how to curb teenage pregnancies and child marriages	MoE (counselling departments); religious bodies, and line NGOs	Funding
9.	**Clubs** could be strengthened in schools to provide young people with a platform to discuss and educate on the causes and prevention of teenage pregnancies and child marriages. Informative clubs for both boys and girls to educate and sensitize them about factors leading to teenage pregnancies and child marriage. The integration of age-appropriate family information into the club items of discussion is recommended.	MoE, Club patrons, line NGOs, School administrators	Learning materials, Funding for club

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Appendix II: Sample Tools for Data Collection

1. Questionnaire

TP & CM Questionaire Data c

2. FGD Guide

FGD for Teenagers

FGD Tool -Teenagers Final 2n

3. KII Guide

Key Informant Interview Guide – Stakeholders

KII Tool for Stakeholders.docx

4. Case Study Guide

A Case study tool for Teenage Pregnancy and Child Marriage

Case Study Tool - FAWEK Final 2nd De

5. Informed Consent Form

Informed Consent Form

ASSENT FORM for Teenagers and Chilc

Appendix III: Part IV of the Act of the Kenya Data Protection Act 2019

The following is the link to the Kenya Data Protection Act 2019

https://www.kentrade.go.ke/wp-content/uploads/2022/09/Data-Protection-Act-1.pdf

Appendix IV: State of Teenage Pregnancies from 2016 to 2020

Status of teenage pregnancies per county 2016-2020

Number of adolescents presenting with pregnancy at first antenatal clinic

County	2016			2017			2018			2019			2020			2016-2020
	10-14 years	15-19 years	Total	10-14 years	15-19 years	Total	10-14 years	15-19 years	Total	10-14 years	15-19 years	Total	10-14 years	15-19 years	Total	Change
Mombasa County	413	4344	4757	368	7164	7532	258	6664	6922	49	3635	3684	44	2321	2365	-2392
Kisumu County	381	12472	12853	493	13344	13837	337	8034	8371	311	7241	7552	402	6112	6514	-6339
Busia County	307	10283	10590	120	9804	9924	348	11077	11425	279	6421	6700	187	5520	5707	-4883
Migori County	875	14196	15071	597	12285	12882	669	12331	13000	534	10199	10733	455	8887	9342	-5729
Kilifi County	499	9836	10335	228	10914	11142	198	15392	15590	134	9344	9478	127	6928	7055	-3280
Uasin Gishu County	853	5758	6611	451	8253	8704	235	9713	9948	127	9328	9455	108	4642	4750	-1861
Siaya County	389	10168	10557	381	10674	11055	387	13309	13696	386	10472	10858	349	7409	7758	-2799
Kisii County	695	10606	11301	597	10326	10923	909	12633	13542	723	10257	10980	747	8854	9601	-1700
Kwale County	1333	7853	9186	653	9235	9888	318	12162	12480	447	10804	11251	99	8180	8279	-907
Machakos County	239	5557	5796	354	7180	7534	175	9780	9955	368	10530	10898	157	5275	5432	-364
Kitui County	411	6415	6826	388	8627	9015	795	10691	11486	384	8087	8471	289	6179	6468	-358
Lamu County	25	1088	1113	102	1669	1771	43	1422	1465	22	1285	1307	9	1053	1062	-51
Taita Taveta County	19	1419	1438	62	2351	2413	44	3550	3594	74	1516	1590	32	1396	1428	-10
Kirinyaga County	90	2241	2331	259	2868	3127	78	4220	4298	52	3259	3311	52	2370	2422	91
Homa Bay County	936	10388	11324	1150	13496	14646	891	13842	14733	957	12687	13644	1181	10686	11867	543
Kiambu County	226	9415	9641	216	10731	10947	353	14506	14859	378	13148	13526	206	10176	10382	741
Embu County	49	2056	2105	340	2737	3077	25	2083	2108	25	2126	2151	29	2281	2310	205
Baringo County	782	3196	3978	992	3202	4194	1143	5080	6223	211	4706	4917	203	4173	4376	398
Nyandarua County	76	2011	2087	116	2346	2462	250	3586	3836	47	3877	3924	25	2281	2306	219
Makueni County	225	4604	4829	258	6294	6552	229	7928	8157	286	6948	7234	167	5229	5396	567
Nyamira County	197	4584	4781	263	4702	4965	261	5658	5919	427	7828	8255	361	5042	5403	622
Nakuru County	727	9985	10712	867	13008	13875	930	17110	18040	1504	14992	16496	143	12307	12450	1738
Nairobi County	5187	12991	18178	4030	21784	25814	3481	23758	27239	2432	24113	26545	2598	19561	22159	3981
Garissa County	317	2207	2524	377	3018	3395	817	3643	4460	901	3989	4890	81	3087	3168	644
Muranga County	44	4352	4396	92	4499	4591	86	6595	6681	60	6600	6660	61	5458	5519	1123
Bomet County	280	6704	6984	520	9032	9552	202	9873	10075	375	10778	11153	249	8905	9154	2170
Tana River County	242	3124	3366	81	3451	3532	119	5450	5569	143	5324	5467	324	4260	4584	1218
Kajiado County	1455	6266	7721	878	6632	7510	1138	9204	10342	1523	11333	12856	1349	9523	10872	3151
Isiolo County	43	1414	1457	39	1640	1679	166	2606	2772	14	2851	2865	103	1989	2092	635
Nyeri County	58	1565	1623	359	2364	2723	17	2594	2611	22	3000	3022	22	2358	2380	757
Wajir County	223	2119	2342	234	2408	2642	350	2803	3153	270	2684	2954	194	3263	3457	1115
Bungoma County	1613	7232	8845	1352	16284	17636	747	18439	19186	592	13920	14512	501	12875	13376	4531
Kericho County	201	5313	5514	176	5221	5397	556	8464	9020	1006	9517	10523	943	7484	8427	2913
Meru County	341	9073	9414	1060	12286	13346	711	15346	16057	473	15353	15826	1341	13328	14669	5255
Elgeyo Marakwet County	112	2433	2545	115	2887	3002	148	3989	4137	59	3960	4019	91	3913	4004	1459
Nandi County	683	3739	4422	713	5198	5911	385	7852	8237	277	7794	8071	219	6870	7089	2667
West Pokot County	325	5339	5664	332	5372	5704	361	8395	8756	493	8067	8560	327	9481	9808	4144
Narok County	347	8012	8359	672	10189	10861	688	14599	15287	910	14052	14962	827	14398	15225	6866
Tharaka Nithi County	50	1854	1904	300	2414	2714	139	3877	4016	151	3864	4015	55	3508	3563	1659
Turkana County	490	3782	4272	729	5734	6463	549	7333	7882	560	7830	8390	450	8000	8450	4178
Samburu County	81	2325	2406	66	2027	2093	196	3742	3938	496	4152	4648	509	4396	4905	2499
Laikipia County	99	2585	2684	144	3654	3798	401	4598	4999	106	5400	5506	169	5320	5489	2805
Vihiga County	69	2552	2621	83	3817	3900	178	6442	6620	176	7179	7355	165	6157	6322	3701
Marsabit County	282	1265	1547	218	1533	1751	527	2406	2933	227	3457	3684	175	3698	3873	2326
Trans Nzoia County	318	3667	3985	305	5227	5532	591	11388	11979	310	11687	11997	201	11400	11601	7616
Kakamega County	580	3626	4206	1096	7369	8465	410	16559	16969	532	16957	17489	394	14374	14768	10562
Mandera County	169	263	432	290	910	1200	612	3958	4570	288	4168	4456	236	3714	3950	3518

Source: KDHIS

Source: The Office of the High Commissioner for Human Rights 2022.
https://www.ohchr.org/sites/default/files/2022-05/kenya_annex.pdf

Appendix V. County Based Statistics

Central and Nakuru Counties

The central counties included Kiambu, Muranga, Nyandarua and Nyeri. The counties, along with Nakuru County had the following leading reasons for teenage pregnancies.

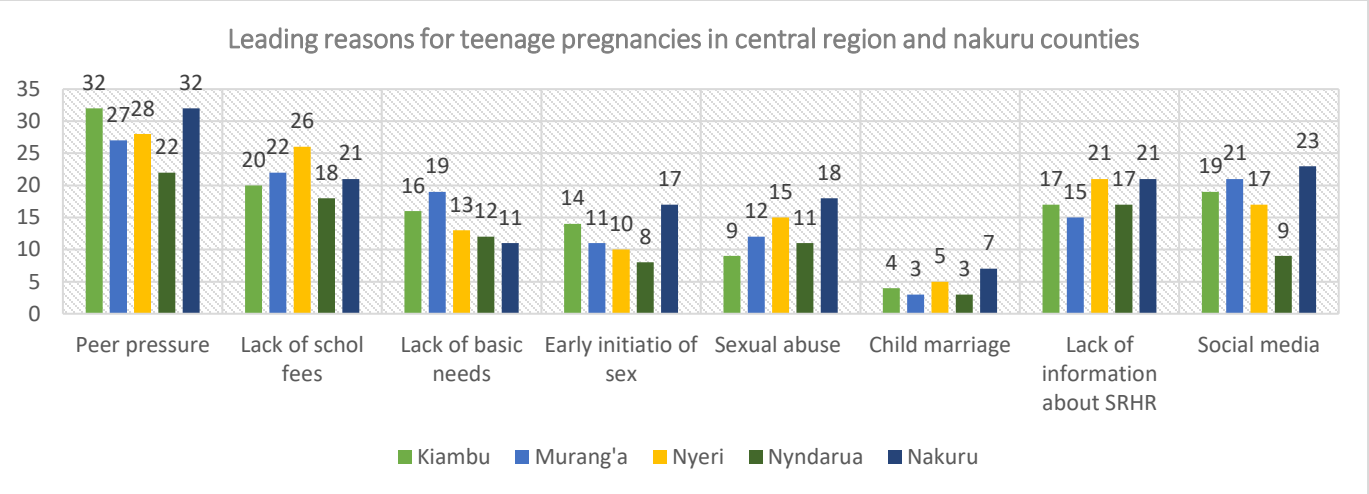


Figure 30: Leading reasons for teenage pregnancies in central region and Nakuru counties

Narok, Kajiado, Turkana and Garissa Counties

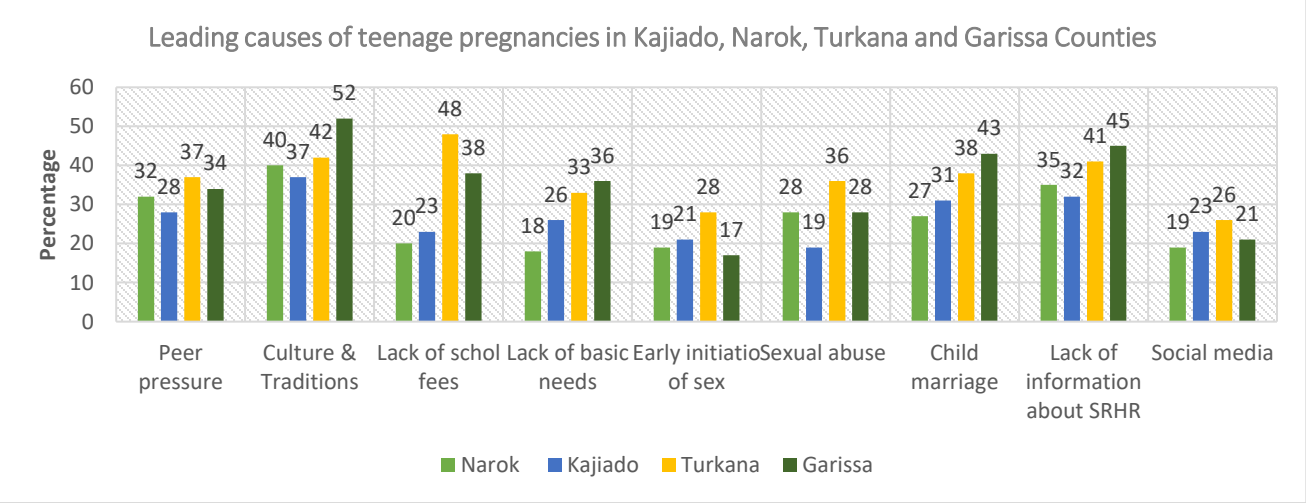


Figure 31: Leading causes of teenage pregnancies in Narok, Kajiado, Turkana and Garissa Counties

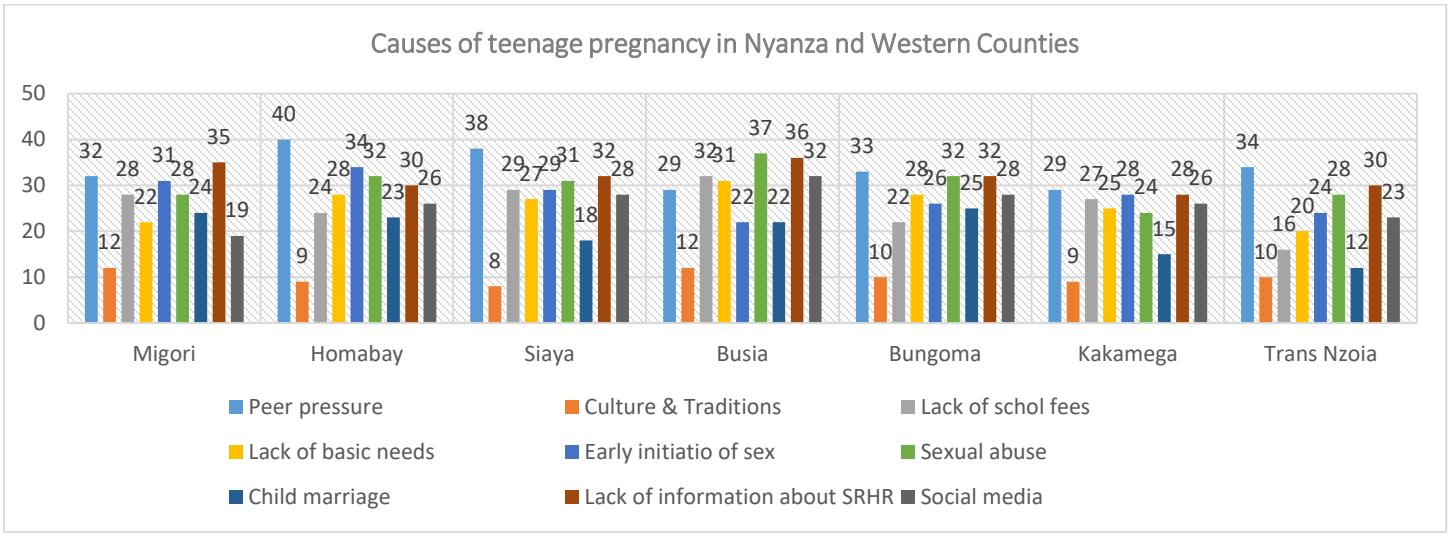
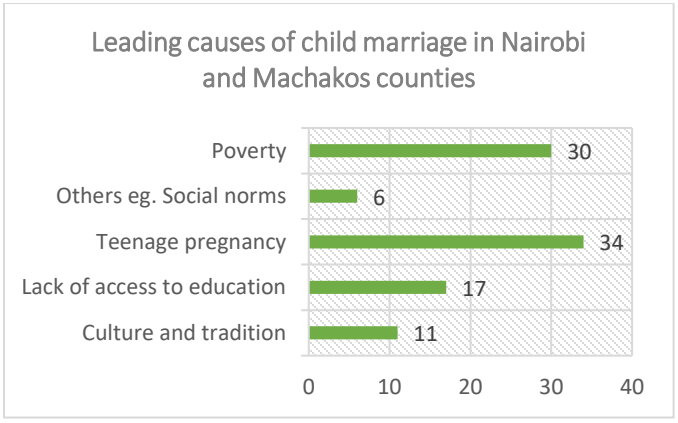
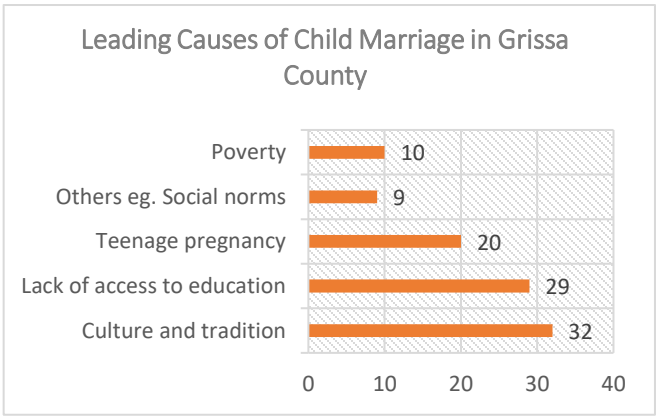
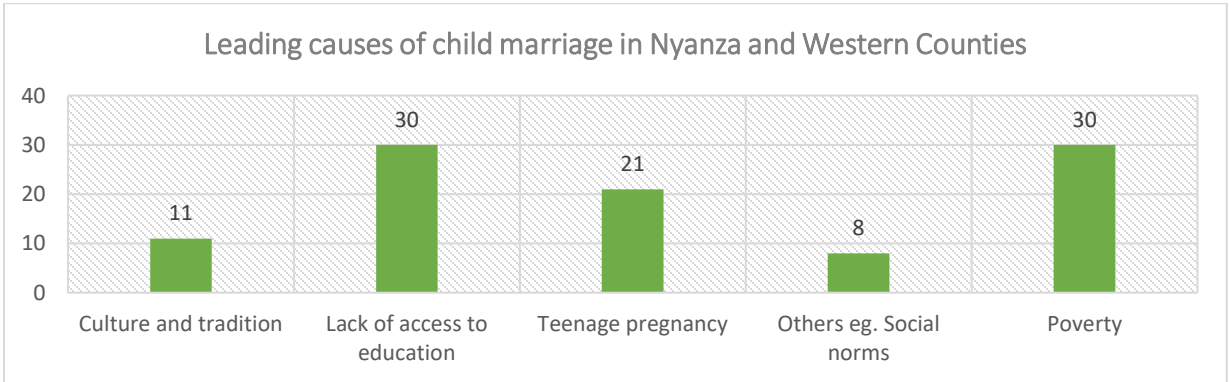


Figure 32: Leading causes of teenage pregnancies in Nyanza and Western counties

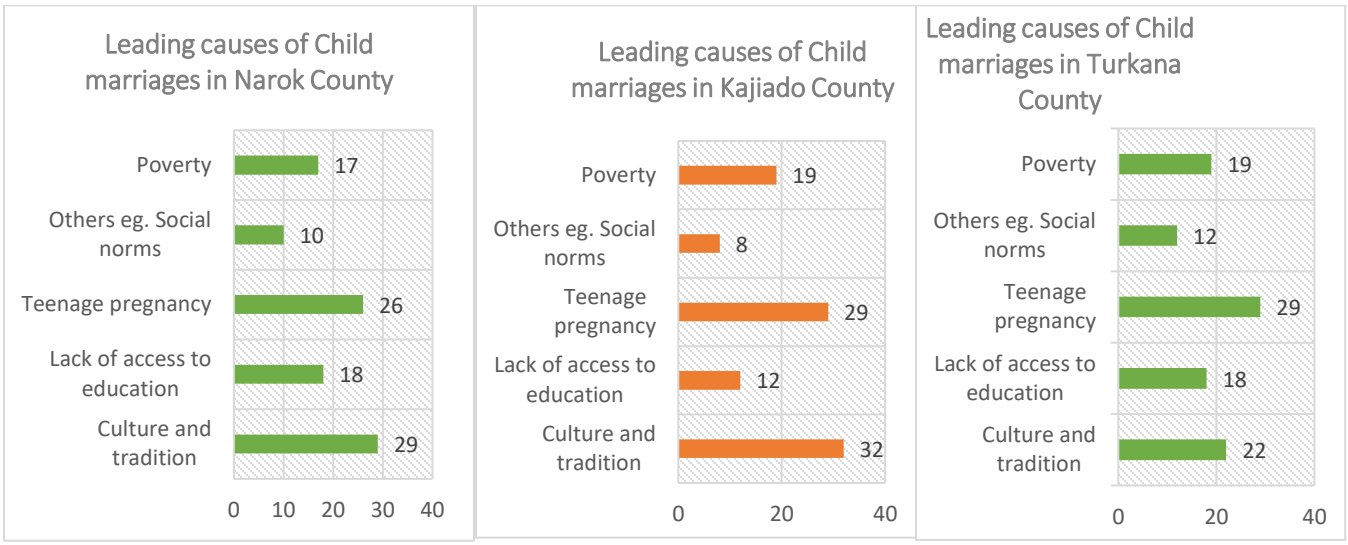




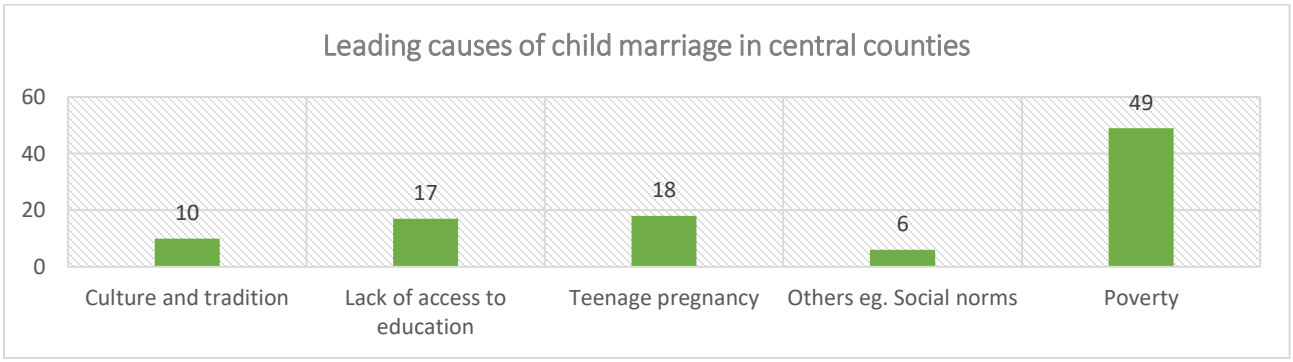
Leading causes of child marriage in Nairobi Machakos and Garissa



Leading causes of child marriage in Nyanza and Western counties



Leading causes of child marriages in Narok, Kajiado and Turkana



Leading causes of child marriage in Central Region counties

Appendix VI: A Case Study of Teenage Pregnancy in Nairobi County

Below is a case study detailing the experience of a 16-year-old teenage girl (whose details have been changed for protection purposes) with rejection and ridicule from her family and dealing with the mental health issues to being suicidal because of the rejection.

Janice (not her real name), a 16-year-old from Nairobi County, comes from a family of five, including her parents and three siblings. During the December 2021 holiday, she traveled to her family's upcountry home to attend her cousin's birthday party. After the celebration, she decided to spend some time at her boyfriend's place. He was a bodaboda rider, and that evening, while drunk, they engaged in unprotected sex, resulting in her pregnancy.

Janice chose not to inform her mother about the pregnancy initially, as it was not yet visible. It wasn't until after she completed her KCSE exams in March 2022 that she realized she was five months pregnant. When her mother discovered the situation, she was deeply upset and even borrowed money from friends to help Janice procure an abortion. However, Janice refused to go through with it, instead pressuring her boyfriend to take responsibility and support her once the child was born.

Janice eventually gave birth, but her boyfriend provided little support. Her mother ended up taking on most of the responsibilities. Both of her parents neglected her, choosing to prioritize the education and welfare of her siblings by paying their school fees and providing for them, while Janice was left on her own. Meanwhile, her boyfriend moved on, started dating another girl, and significantly reduced the limited help he was offering.

Now, Janice deeply regrets becoming pregnant, as it brought her education to an abrupt end and added significant responsibilities to her life at a young age. The experience also caused her family to turn away from her, and she did not return to school, effectively halting her education.

Reflecting on her experience, Janice believes that other girls should be educated about the dangers of engaging in early sexual activity and the impact it can have on their education, health, and future. She also advocates for parents and schools to provide sanitary towels and other resources to protect girls from predatory boys and men who may take advantage of their vulnerabilities.