EXPLORING THE SOCIO-ECONOMIC AND INFORMATION DETERMINANTS OF TEENAGE PREGNANCY IN WEBUYE WEST SUB-COUNTY, BUNGOMA COUNTY, KENYA

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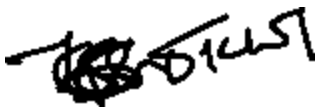
DECLARATION

This project is my original work and has not been submitted for examination in any other institution or University.

Signed:  Date: November 17, 2022

Mercy Mwongeli

This project has been submitted for examination with our approval as the University supervisors:

Signed:  Date: July 21st 2023

Prof Tom Ondicho

DEDICATION

To my dear departed mother, for being my true north and motivation to be the best version of myself.

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I extend my gratitude to the entire faculty and staff members at the Department of Anthropology, Gender, and African Studies (DAGAS) for the assistance and support granted during the planning and development of this research, and for their guidance and useful insights during my defence.

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ABSTRACT

This was a qualitative study on determinants of teenage pregnancy in Webuye West Sub County, Bungoma County Kenya. The study specifically sought to explore the socio-economic and information determinants of teenage pregnancy in the study area. The study was guided by the theory of reasoned action and data was obtained through in-depth interviews, key informant interviews and focus group discussions. The data collected was analysed thematically and results reflect verbatim quotes capturing and amplifying the voices of the informants. The results reveal that peer pressure, and the desire to fit in, is a key determinant of teenage pregnancy in the study site. In some instances, families are forced to marry off their girls as a source of income through dowry payment. Poverty is a critical determinant of teenage pregnancy where low purchasing power leaves girls vulnerable to sexual exploitation and abuse as they are unable to negotiate for safe sex, leading to unintended pregnancies. The study recommends the institution of community-responsive programs that will empower and increase teenage girls' agency to make informed choices concerning their sexuality. The study recommends the implementation of economic education programming to improve the livelihoods of families, and research and programming to increase information by parents and guardians, through formal and non-formal channels, to equip teenagers with information, knowledge, services, and products that will aid in the reduction of teenage pregnancies and other sexually transmitted diseases and infections.

LIST OF ABBREVIATIONS AND ACRONYMS

APHRC	African Population and Health Research Centre
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
IAGAS	Institute of Anthropology, Gender, and African Studies
KDHS	Kenya Demographic and Health Survey
KNBS	Kenya National Bureau of Statistics
MOH	Ministry of Health
PEPFAR	United States President's Emergency Plan for AIDS Relief
SRHR	Sexual, Reproductive Health and Rights
UNAIDS	United Nations Joint Programme on HIV and AIDS
UN DESA	United Nations Department of Economic and Social Affairs
UNODC	United Nations Office on Drugs and Crime
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER ONE

BACKGROUND OF THE STUDY

1.1 Introduction

Teenage pregnancy is a global social and health challenge, owing to its diverse health and demographic consequences (Mkwananzi, 2016, WHO, 2018). Adolescent pregnancies occur across all socio-cultural, and economic divides, occurring across high-, middle- and low-income countries. Globally, in 2018, approximately 21 million teenage girls presented with pregnancy: with 71% (16 million) presenting in the developing world (UNFPA, 2018). Of the 21 million adolescent girls who become pregnant, 57% (12 million) of them were in the developing world. An estimated 777,000 girls aged below 15 give birth annually in developing regions, and there are at least ten million (10 million) unintended or unplanned pregnancies reported (UNFPA, 2013). These pregnancies not only pose a health risk, but they also pose a social risk to adolescent girls concerning the discontinuation of their education and social isolation within the communities they live in. The health impact of these unintended pregnancies contributes to the rise in HIV incidence and prevalence among this age group, across all economic divides (UNAIDS, 2021). Low socioeconomic status predisposes teenagers to sexual exploitation, in a bid to meet their basic needs, coupled with a low agency to negotiate first sexual encounters and use of protection, for safe sex (UNAIDS, 2021). Teenagers in low-income areas lack educational and employment opportunities; Eastern Asia presented the highest number of unplanned teenage births (95,153) followed closely by Western Africa (70,423) with the least number occurring in Switzerland (4,918) (WHO; 2016).

There are other factors leading to teenage pregnancy, ranging from cultural pressure that perpetuates retrogressive practices such as early marriages. The economic disparity contributes greatly to retrogressive cultural practices like early marriage; 39% of girls in the least developed countries are married before the age of 18, with 12% being married before the age

of 15. Pregnancy is perceived as a social safety net or security, in cases where teenagers lack opportunities and access to education and employment opportunities. In such settings, early marriage and motherhood are often viewed as the only viable option for teenagers to thrive and survive (UNFPA, 2018).

Low levels of sexual reproductive health and rights information among teenagers contribute to early pregnancies, even among teenagers who may wish to avoid getting pregnant. The lack of adequate information and knowledge leaves these teenagers vulnerable to making poorly informed choices regarding their sexuality. Access to contraceptives, owing to healthcare provider biases also contributes to high levels of teenage pregnancies. Restrictive legal and policy framework across developing countries regarding the provision of contraceptives to perceived underage and unmarried young girls largely contributes to the increase in teenage pregnancy (UNFPA, 2018). Adolescence is a transitional age from childhood to adulthood, known for the high rate of emotional and not rational decision-making by adolescents and teenagers. This is because young people in this transition phase lack sufficient agency and autonomy to make rational, sound, and positive decisions concerning their sexual and reproductive health. This lack of agency to make the right decisions and choices is a large contributor to the estimated ten million (10 million) unintended pregnancies presented in developing regions. Sexual violence is a major contributing factor to teen pregnancy; in Kenya, a third of girls (one out of three) reported that their first sexual encounter was not consensual, rather, it was coerced (KNBS, 2014). In addition, one out of five girls reports being a survivor of sexual and other forms of gender-based violence, statistics and facts that predispose teenage girls to early and unplanned pregnancies (KNBS, 2014).

Across the globe, early pregnancies are accompanied by numerous health concerns, mainly mortality, morbidity, and poor health outcomes for children. Maternal mortality among teenage

mothers aged between 15-49 presents astronomical figures, accounting for 99% of maternal deaths. Other health complications faced by teenage mothers that often lead to their deaths include eclampsia, puerperal endometritis, and systemic infections (WHO, 2016). Unsafe abortions related to unplanned pregnancies, especially in the developing world, where abortion laws and regulations are stringent and do not offer free choice to teenage mothers contribute largely to teenage maternal mortality, with an estimated 3.9 million unsafe abortions reported annually across the developing regions among young girls aged 15-19.

With the above context in mind, the health and well-being of newborns, as well as teenage mothers, cannot be overstated. Babies delivered by teenagers, especially by mothers aged below the age of 20 face numerous challenges and complications, including, and not limited to low birth weight, and life-threatening neonatal health complications, to mention but a few. In cases where rapid repeat teen pregnancy is witnessed, the long-term health risks for the mothers and children have been documented, to reinforce the risks of teenage pregnancies (UNFPA, 2016). In the developing world, social isolation of pregnant teenagers is commonplace, in extreme cases, pregnant teenagers are ostracised by society. These teens face stigma, discrimination, and the impacts of rejection and violence meted on them by their partners, parents, and peers. Statistically, teenage mothers are highly susceptible to sexual and gender-based violence, specifically intimate partner violence, largely owing to their inability to negotiate for their sexual health and rights and well-being (WHO, 2016). Teenage pregnancy and childbearing lead to school drop-out, even in countries like Kenya where the back-to-school policy for teenage mothers is institutionalise, and social and economic constraints do not provide a conducive environment for these teenagers to continue their education. This fully jeopardizes the girls' future, including their ability to secure meaningful employment and reach their full potential (NCPD, 2021).

Kenya is ranked among the nations with high rates of teen pregnancy, standing at 18%; translating to about one in every five teenage girls aged between 15-19 who are either pregnant or have already had their first childbirth experience. This cumulative rate is diverse across the girls' ages, where those aged 15 have a 3% pregnancy rate, to 40% for girls aged 19. The age disparity is also seen when it comes to county data where some counties are disproportionately affected by the crisis. The continued teen pregnancy crisis indicates continued discontinuation of education by teenagers, increased health complications, increased mortality, and morbidity increased unsafe abortions and continued perpetuation of harmful cultural practices including child marriages. Teen pregnancy, in essence, presents a hindrance and barrier to the growth and development of an individual and society, by reducing the capacity of the youth, who are the most productive members of society, to fully contribute to development. In essence, the nation is unable to benefit fully from the demographic dividend. With the prevailing social concerns and backlash around teenagers accessing contraception and age-appropriate sexual reproductive health and rights information, teenagers are left susceptible to inaccurate information peddled by their peers or accessed via social media (Ministry of Health, 2015). The religious community has also presented a strong position, opposing access to contraception for teenagers, deeming it unethical and unchristian, yet we see the rate of teenage pregnancy on the rise among this age group. This is a classic case of burying our heads in the sand, as a community, and this study aims to address such gaps.

Current statistics in Kenya show that one out of every young girl aged between 15-19 is either pregnant or has already given birth (KNBS, 2014). In Sub-Saharan Africa, Kenya has the third largest early and teen pregnancy rates, reporting an average of 82 teen births per every 1,000 births recorded (UNFPA, 2018). Out of the 21 million teenage girls who presented with pregnancy globally, 71% (16 million) presented in the developing world (UNFPA, 2018).

Between July 2016 and June 2017, 378,397 girls were pregnant in Kenya (UNFPA, 2018). Annual data shows that an average of 13,000 girls drop out of school owing to unintended and unplanned pregnancies (KNBS, 2014). The Covid-19 pandemic and the ensuing national lockdown saw a spike in the number of teenagers presenting with pregnancy, with an estimated 152,000 teenage mothers recorded between March and May 2020 (NCPD, 2021). The rise in teenage pregnancy during the Covid-19 pandemic is attributed to three main factors; poverty; lack of access to basic commodities, in many cases such as sanitary products and the full shutdown of health facilities that led to decreased access to sexual reproductive health information, products and services.

The Covid-19 pandemic led to widespread job losses, across the globe, and Kenya was no exception, causing undue strain to an already economically stretched population. Before the pandemic, data indicated that a third of the population was surviving on under one dollar a day (KNBS, 2020). This translated to a population unable to meet their basic needs, and even afford basic commodities, especially sanitary pads, a commodity dangled as bait for teenage girls who are not able to access them at their household level. In Kenya, sanitary towels are provided to students at no cost, with the closure of schools during the pandemic, the school-going girls lacked an avenue to access this essential commodity. This led to a subsequent increase in transactional and intergenerational sex and the ensuing teen pregnancies (Plan International, 2021). This exploitation occurs largely in the informal settlements across the country, where young girls, especially those aged below 19, are exploited by men who are often older than them, who demand sex in exchange for favours, both financial and otherwise. These young girls, unable to negotiate for safe sex, give in to the demands in a bid to access basic commodities and essential services such as showers and sanitary towels. Young girls living in informal settlements in Kenya face adverse challenges where in many instances, they only

have access to one source of clean water, which is often shared by more than 1,000 people (MSF, 2021). This presents a sanitary and social challenge where the young girls seek to ensure their cleanliness, in strained circumstances. The situation becomes grave during menses when girls require sustainable access to clean water to ensure sanitary conditions during this period. The social and economic strain experienced by these girls, and the ensuing inability to seek sexual reproductive services and products after the acts of coerced sex, contributed largely to the stark rise in teen pregnancies across the country. To redirect primary services and shut down some, in a bid to flatten the Covid-19 curve, the government inadvertently contributed to the increasing menace that is teen pregnancy in Kenya (MSF, 2021).

> *"The collateral damage of taking that kind of approach is that when we shut down these routine services [for girls], we saw an increase in maternal and child death from preventive causes." (MSF, 2021).*

Teenage pregnancy presents an additional challenge of HIV infection as young girls are engaging in unprotected sex, owing to their inability to negotiate for safe sex. In Kenya HIV incidence and prevalence have been on a decline, except among adolescents and young people (KASF II, 2021). KASF recommendations indicate the need to take immediate action concerning counties that are considered medium risk, concerning teenage pregnancy and HIV incidence, as these are the counties that present an immediate challenge in addressing this dual-faced challenge.

Education provides an avenue of empowerment for girls, providing them with the prerequisite tools to attain their highest potential and increase their agency to make wise decisions and choices that will positively impact their lives. Access to education is associated with improved life outcomes for girls. When girls stay in school and access education, they are better equipped to make informed choices concerning their sexual and reproductive health and rights; basic education provides girls with information that helps to improve their agency and capacity to

attain their goals and highest quality of life. This reduces their level of vulnerability to exploitation and susceptibility to making poor or detrimental life choices (UNFPA, 2018). National data reflects high levels of teenage pregnancies among girls with a primary level of education or below; 33% of teenage girls who have not accessed education have begun childbearing vis a vie 12% presented among girls who have attained at least secondary education or any other higher level of education (KDHS, 2014).

Sexual reproductive health information, products and services are available at public health facilities, however, there is low uptake owing to the level of youth-friendly and responsive service provision at these facilities, standing at 10% (SARAM, 2013). Access to this information, products and services not only presents a challenge concerning teenage pregnancy but predisposes adolescents and young people to other health risks such as HIV and other sexually transmitted diseases and infections. Teenagers, who cannot afford to access these services at private facilities fear going to the public health facilities owing to fear of judgement by the elderly health care providers, and fear of the service providers being neighbours or peers to their parents and telling on them. The most common contraceptive used by teenagers is the male condom, this is because it is easy to access and not as cumbersome to use, compared to the female condom (KNBS, 2019). Contraception use among sexually active unmarried girls aged 15-19, specifically the male condom, stands at 49.3% and 64.3% among those aged 20-24 (KNBS, 2014). These numbers are low and show a clear picture of the risk level among teenage girls, with a higher risk perception among the older girls, whose rate of use of modern contraception is higher than that of the younger girls (KNBS, 2014). Despite efforts to eradicate culturally retrogressive practices like early marriage, the practice persists. Of the married teenage girls aged between 15-19, only two out of five (36.8%) of them use modern contraception, with a 23% unmet need for contraception: directly translating to one out of four of these girls presenting an unmet need for modern contraception (KNBS, 2014).

National statistics indicate teenage pregnancy stands at 18% in Kenya, with Bungoma County recording a 14% rate (KDHS, 2014). National teenage pregnancy statistics rank Bungoma County second out of the top 10 high burden Counties (Sauti Sasa, 2019). In Webuye West Sub-County, recorded cases of teenage pregnancy in 2018 were coupled with additional health and social challenges such as complete abortions, incomplete abortions, abortions sepsis which required hospital treatments and dropping out of school, which in turn results in interfering with their furthering of education and attainment of their full potential (USAID, 2022).

1.2 Problem Statement

Teenage pregnancy is identified as a leading cause of unmet potential for girls, globally. Early childbearing causes disruption of education for teenagers, leading to the loss of not only educational but also social and economic opportunities (Darroch et al, 2016). The provision of age-appropriate comprehensive sexuality education to teenagers is critical to empowering teenagers and enabling them to make informed decisions concerning sex and their sexuality. It is therefore critical for the gap between research on teenage pregnancy, policy, and practice to be filled (Darroch et al, 2016). With a rapidly evolving society, fuelled by globalization and global connectivity through the internet, education provided to teenagers must be customised to respond to the rapidly evolving environment, while considering the diverse socio-cultural and behavioural attributes of communities and individuals. This is to ensure that the information provided is useful and applicable to teenagers and minimize the negative impacts of teenage pregnancy (Darroch et al, 2016). Studies indicate that teenagers with an early sexual debut have often been exploited and this, a human rights violation, goes largely unreported. Equipping teenagers with information to empower them not only prevent exploitation but also capacitates them to report cases of violation, without fear of any repercussions.

Teenage pregnancy is linked to poor educational outcomes, including discontinuation, poor health outcomes and poor social outcomes for teenagers. More research is therefore required to delve into the teen pregnancy crisis and identify not just the known causes, but the drivers of teen pregnancy, thereby empowering all stakeholders to adequately respond to the crisis (Vogel et al, 2015). Demographic Health System data reveals that teenagers lack the agency to make informed decisions concerning sexual debut and prevention of pregnancy, even in cases where they would like to prevent pregnancy. The information available from research is broad-based and does not provide detailed solutions to support these teenagers to prevent unintended pregnancies (Hussain, 2016). Sexual reproductive health information at the global, regional, national, and local levels is insufficient, concerning details around sex, sexual debut, sexual orientation, and gender identity. A study conducted on experiences of teenage pregnancy and participation in primary education focused largely on academic performance at the primary level, when it comes to teenage pregnancy and childbearing, ignoring the broader impacts of teen pregnancy on the holistic well-being of the teenager (Barmao, 2015).

Bungoma County has a 14% rate of teen pregnancy, 61% contraceptive prevalence rate and 27% unmet need for contraception, placing it as a medium burden county. In Kenya, counties that present low uptake of contraceptives have high rates of teenage pregnancies (KNBS, 2015). The study was therefore guided by the below study questions:

1. What are the socio-economic determinants of teenage pregnancy in Webuye West Sub-County?
2. What is the level of sexual and reproductive health and rights information among teenage girls in Webuye West Sub-County?
3. What sexual reproductive health and rights products and services are accessible to teenage girls in Webuye West Sub County?

1.3 Objectives of the Study

1.3.1 Overall Objective

To access the determinants of teenage pregnancy in Webuye West Sub-County, Bungoma County, Kenya.

1.3.2 Specific Objectives

i. To establish the socio-economic determinants of teenage pregnancy in Webuye West Sub-County.
ii. To examine the information determinants of teenage pregnancy in Webuye West Sub-County.
iii. To examine access to reproductive health and rights products and services in Webuye West Sub County.

1.4 Assumptions of the Study

i. Peer pressure, social media and household poverty are key determinants of teenage pregnancy in Webuye West Sub County.
ii. Correct information on sexual reproductive health and rights positively correlates to teenagers in Webuye West Sub County.
iii. Access to quality reproductive health care services and products influences teenage pregnancy in Webuye West Sub County.

1.5 Justification of the Study

National studies (KDHS, 2014) carried out on teenage pregnancy have focused on addressing the high rates of teenage pregnancies. Data collected and collated from studies including the Kenya Population-Based HIV Impact Assessment carried out between 2018 and 2019, and the Kenya HIV Estimates Report of 2018 outline the rates of teenage pregnancy across the country and specific regions that bear the brunt of teenage pregnancy. However, very limited research has been carried out on drivers, causes, knowledge and attitude towards pregnancy and teenage pregnancy, cultural attributes contributing to teenage pregnancy and ease of access to SRH information, services, and products, to guide interventions within the study area. It is therefore imperative that this study is carried out to delve into, and document, the specific drivers of teenage pregnancy within Webuye West Sub-County, Bungoma County, Kenya. The findings and outcomes of this study would be of great importance and interest to the various stakeholders working in the SRH field, with a specific focus on teen pregnancy; they would give parents and community leaders insights about the increasing trends in teenage pregnancies in Webuye West Sub-County and possible mitigating measures to address the issue. It would similarly go a long way in shifting the mindset of community members to support access to sexual reproductive health and rights information, services, and products for e young people.

The finding of the study would aid non-governmental, community-based, and local organizations to prioritise resources and efforts to address teenage pregnancy on the key drivers, as opposed to broad national drivers that do not apply to the Sub-County. The findings would also highlight to teenage mothers the consequences of early pregnancies. Furthermore, the findings of this study would be available for use as a baseline in future studies and research around drivers of teenage pregnancy within the study area, and across the country as this is a key emerging issue among teenage girls. These findings would also be utilized as reference

material for policy working to improve the SRH outcomes of adolescent and teenage girls, as well as in the advancement of academic work in the arts and social sciences.

1.6 Scope and limitations of the study

This study was undertaken in Webuye West Sub-County, Bungoma County, Kenya, with a focus on teenagers aged 18 and above who got pregnant in their early teen years or were pregnant. The study was carried out in Webuye West Sub-County, Bungoma County Kenya and explored the socio-economic determinants of teenage pregnancy, the level of information on sexual reproductive health among teenagers and access to sexual reproductive health and rights products and services within the community. Time and financial constraints limited the sample size selection, limiting the qualitative findings collected. These constraints posed a challenge concerning the generalization of the study findings. Therefore, this may affect the findings and conclusions of the study. Owing to the prevailing Covid-19 pandemic, physical interactions with desired respondents may not be as extensive as desired, in line with observing the laid-out protocols. Noting that Webuye West Sub-County differs from other sub-counties in Bungoma County, concerning geography, socioeconomic, religious, political, and environmental settings, it is worth noting that the outcomes, findings, and recommendations according to this study were only applicable to Webuye West sub-County, Webuye County, Kenya.

1.7 Definition of key terms

Abortion: The deliberate termination of a pregnancy before the 28th week.

Adolescents: Persons aged between 10 and 19 years in a transitional stage from puberty to adulthood.

Contraceptive: Any device or mechanism used to prevent pregnancy in women.

Contraceptive prevalence rate: This is the proportion of women ages 15-49 currently using or having partners who are using at least one form of a modern contraceptive.

Mature minor: A person aged below 18 but heading a household

Teenager: A young person aged between 13 to 19.

Teenage Pregnancy: Pregnancy occurs in a human female aged below 20.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter presents reviews of literature from books, articles, journals, and periodicals related to teenage pregnancies. The literature presented covers perceived social and cultural causes of teenage pregnancies, economic causes of teenage pregnancy and level and access to sexual reproductive health and rights information, products, and services and their impact on teenage pregnancies. The last section of this chapter delves into the Theory of Reasoned Action and its relevance to the study.

2.2 Causes of Teenage Pregnancy

Unplanned and unintended pregnancies among teenage girls pose a global health and social concern, with economically marginalized communities bearing the brunt of the problem. In communities where girls have little to no access to education and economic opportunities, marriage, and unfortunately at very young ages, is considered a way out of the cycle of poverty. Unfortunately, this leads to early and unintended pregnancies, as these young girls relinquish all rights to make any decisions about their bodies, health, and sexuality (Plan International, 2020). The magnitude of teenage pregnancy is well presented through the poor health outcomes documented among teenage mothers and their babies. The causes of teenage pregnancies range from low access to formal education, structured education and ensuring access to SRH information on sexual reproductive health and rights, prevention and elimination of retrogressive cultural practices, low socio-economic status, and gender-based violence and abuse (WHO, 2020).

2.3 Socio-economic causes of teenage pregnancy

2.3.1 Peer Pressure

Peer pressure is the desire to do what others are doing in a bid to fit in and can be difficult to resist during teenage. Teenagers, going through a phase of transition from childhood to adulthood, are faced with numerous challenges, including what choices to make and what company to keep. Teenage pregnancy has been attributed to peer pressure, where teenagers will engage in premature sex to fit in with their friends, who truthfully, or misguidedly, speak of engaging in sex. Unfortunately, the conversation among these peers does not engage conversations around contraceptives and how to prevent unplanned pregnancies and other health risks associated with unprotected sex. Teenagers, in a bid to find their identity and in the search for social values that define their identity end up finding themselves in a jam when the choices they make to fit in lead to unplanned pregnancies (Erikson, 1963.). The need for affirmation by peers only further fuels the heightened poor choices made by many teenagers in their endeavour to fit in (Erikson, 1963). Peer pressure is a critical contributor to teenagers' identity and perception of self, including choices, behaviour, characteristics and perception of society and societal issues (Klein, 2005). The desire to belong is a basic human desire, and people are generally, and naturally more attracted to people who are like them. Teenagers will gravitate to peers who speak the same language they do and hold similar values to them, even when these are detrimental to their overall well-being, all in a bid to fit in (UNFPA, 2015). In many cases, the early sexual debut has been attributed to peer pressure, often linked to sexual abuse. When teenagers have a strong desire to fit in with their peers, they will do whatever it takes, including engaging in sex because their friends are doing the same. In many instances, teenagers will be coerced by older men to engage in sex, with the fear of the repercussions of saying no and being cast out by their friends in their minds, they give in (Laura *et al* 2016). An individual behaves similarly to those they interact with or spend most of their time with.

Teenagers, especially, tend to mirror these traits and perform better in school, while steering clear of mishaps such as early pregnancies, while the reverse is true (Brown, 1993). During the teen years, the agency of teenagers is in the development phase, it is a critical stage in life. Sexual reproductive health conversations are not openly had within domestic settings, and therefore, teenagers will seek this information from their peers, and so, follow, even when the advice and guidance is wrong. Seeking sexual reproductive health and rights (SRHR) information from peers and ensuing high rates of unprotected sex is a direct contributor to the increasing numbers of teen pregnancies (UNICEF, 2008). Risk perception among teenagers is proven low; teenagers are often not weary of the implications of unprotected sex. This has often been attributed to a low level of knowledge of the risks of unprotected sex, however, most teenagers get involved in high-risk sexual activities without protection to be like their friends. Unprotected sex is perceived as a sign of love and trust for their partners, -ill-guided as is, with the consequential unplanned pregnancies that ensue (Aidoo, 2016).

2.3.2 Alcohol and drug abuse

Teenage, an exploratory phase in life, provides a rife space for teenagers to explore with alcohol, drugs, and other substances within their reach. The lack of self-control and cognisance of limits among this age group is directly linked to their incapacitation when they indulge in the use and abuse of alcohol and drugs. This incapacitation leads to poor choices, including engagement in unprotected sex that leads to teenage pregnancy. These pregnancies are not only a risk to teenagers but also to the babies they carry, including the heightened risk of foetal exposure to additives and teratogenic substances. During the puberty and teenage stages, many teenagers engage in drinking alcohol and experimenting with drugs in social settings, with little to no patronage of elders to offer guidance and deter them from the negative impacts of drug and substance abuse (UNODC, 2018). Teenage, being a fragile developmental phase, leaves teenagers vulnerable to the consequences of poor choices, such as deterioration of the brain

occasioned by binge drinking. Alcohol and drug abuse also reduces the ability of an individual to be rational, in thoughts and actions, leaving adolescents vulnerable to engagement in unprotected sex and ensuing unplanned pregnancies (UNODC, 2018). Drug and substance abuse not only leads to unprotected sex but is closely linked to violence and reckless sexual behaviour whose consequences include the acquisition and spread of sexually transmitted diseases and infections (UNICEF, 2020).

National statistics are reflected on the ground, where we see counties with increasing rates of HIV incidence and prevalence presenting with high rates of unplanned and unintended rates of teen pregnancies. Cultural or traditional brew, easily accessible to teenagers within the county especially during traditional events such as disco ‘matanga’ (funeral) largely contributes to unprotected sex among teenagers and ensuing pregnancies. There are similar trends in other Western Kenyan Counties, including Bungoma County (UNICEF, 2020). The use and abuse of drugs and substances reduce the capacity of teenagers to make informed decisions about their sexuality, leaving them vulnerable to abuse, and, or coerced and unintended sexual intercourse that leads to pregnancy (UNICEF, 2020).

2.3.3 Gender Perspectives

Gender, the roles ascribed to persons by the community based on their sex, as dictated by culture and religion contributes largely to teen pregnancy, where women and girls are assigned the role of mothers, caregivers, and nurturers (APA, 2008). These gender-based stereotypes curtail girls' and women’s rights and power over their sexuality and agency to make sound decisions concerning their sexuality and wellbeing, denying them the choice of when to engage in sex, when to have children, how to space their children, extending to access and use of SRH information, products, and services, including modern contraceptives that they can use to plan their families and prevent unintended pregnancies. These stereotypes lead to great power

imbalances between men and women in society, where men feel dominant, even over women's agencies, bodies, and choices. When this power is threatened, really or perceptually, unsafe environments rife with violence, including sexual violence are created. These environments are the breeding grounds for unplanned teenage pregnancies, ensuing unsafe abortions and increased sexually transmitted diseases and infections (UNAIDS, 2021). Disco 'matanga' or funeral discos are some of the retrogressive cultural practices that are rampant in the Western and Nyanza regions of Kenya. During these events, girls are exposed to unsafe spaces, with unlimited access to traditional liquor, leading to unprotected, and often unwanted sex. With the absence of parents or guardians for oversight at these events, owing to their indulgence, the risks associated with unplanned and unprotected sex among teenage boys and girls are heightened. These culturally accepted practices, coupled with the lack of parental oversight at such events, is a key determinant of teenage pregnancy in Kenya.

2.3.4 Early Marriage

Globally, retrogressive cultural practices such as early marriage are slowly being erased, through advocacy and information sharing among communities on the dangers and impact of such practices on the lives of teenage girls. This notwithstanding, there are areas in Kenya where the age of marriage is still as low as 12, and often, these unions are between girls and older men; over 40% of young women note that they were in forced unions or quasi-married unions by the time, they turned 18 (UNICEF, 2001). Grim statistics in Kenya indicate a high rate of early teen marriage among young people aged 15-19, with the rate being higher among teenage girls compared to boys, at 13.6% and 0.7% respectively (KDHS, 2014). This data directly translates to the fact that over 50% of young men and women are in unions by the ages of 25 and 20 respectively (KDHS, 2014). Early marriage compels the teenager to take on different responsibilities; those of a wife, mother, and homemaker, leaving no time or space for education (KNBS, 2014). Full completion of studies by a girl ensures an improvement of

her economic and social well-being, and that of her family, by over 30%, compared to a girl who completely discontinues school (PEPFAR, 2016). To end teenage pregnancy and contribute to the ultimate health and well-being of the girl, and society at large, teenage pregnancy, perpetuated through early marriage, must be curtailed (KNBS, 2014).

2.3.5 Sexual abuse and violence

Globally, one out of every three women (30%) indicates being a survivor of one form of gender-based violence or another, in their lifetime. 40-60% of reported sexual assaults occur among girls aged below 15 years (UNWOMEN, 2021). The data on women is clear because most violations committed against boys often go unreported. Girls who are exposed to violence, or sexually violated at an early age record an earlier sexual debut than those who do not experience these violations. In Kenya, girls who suffer sexual violence are likely to fall pregnant before they turn 17 (NCPD, 2020). Intimate partner violence is a key concern in Kenya, with the fight against gender-based violence being at the forefront of both national and county governments' agendas. 37% of women who have ever been married in Kenya report experiencing intimate partner violence, at one point in their union with sexual violence being reported by 13% of these women, emotional violence by 32% of them, physical and or sexual violence by 39% of them and less than half of these women (KNBS, 2014). Intimate partner violence in Kenya is a growing concern and matters surrounding sexual and gender-based violence stem from a lack of age-appropriate comprehensive sexuality education that would empower girls and increase their agency to make informed choices concerning their sexual encounters and partners and knowledge to identify, prevent, respond to and seek help when faced with instances of sexual and gender-based violence.

Sexual abuse and violence are gross human rights violations, denying the survivor the full expression and enjoyment of their rights. Teenage pregnancies ensuing from sexual violations

are a double tragedy as they occur in the context of denial of the right to choose; to choose if to have sex, with whom to have with and how, concerning safe sex (KNBS, 2014). In Kenya, grim statistics show the extent of sexual violence and abuse among young girls and boys aged 15-19, with 6.5% and 2.7% noting to have experienced sexual violence, respectively. The psychological and physical development of an individual greatly affects and impacts how they respond to instances of gender-based violence; young people often do not report violations out of fear of the consequences they may face from the perpetrators, who are often known to them and older. The younger the victims are, the less likely they are to report violations, with only 33% of girls and 20% of boys aged 15-19 reporting, compared to 49% of women and 35% of men aged 40-49 who report violations. numerous cases go unreported, with the perpetrators going unpunished and the survivors bearing the brunt and effects of the violation, including pregnancies and disruption of education and life (KNBS, 2014).

2.3.6 Low socio-economic status

National statistical data indicates that access to basic social amenities in Kenya is low; only 71% of households have access to clean and safe drinking water and only 23% have access to individual sanitary facilities, not shared. Only 36% of households are connected to the electric grid and have access to electricity and only 46% of households have cement floors (KNBS, 2014). These indicators are a clear guide to a key cause of teenage pregnancy, with girls from these marginalized households being highly susceptible to exploitation in the forms of child labour as domestic workers, sexual exploitation through sex work, coercion, and trafficking, all while trying to secure providence for their basic needs. Low socioeconomic status is directly linked to low levels of school completion and transition from primary to secondary and higher levels of learning and ensuing high school dropout rates.

Empirical evidence further indicate that disenfranchised adolescents and teenagers present higher levels of unplanned and unintended pregnancies (26%) as compared to their counterparts from more affluent backgrounds (10%). Teenagers from affluent backgrounds are privileged to enjoy the social protections and safety nets of family and society. The inability of young girls from disenfranchised backgrounds to meet their basic needs, coupled with the obvious vulnerabilities associated with poverty. These vulnerabilities lead to their increased susceptibility to coerced and mostly unprotected sex with older men whom they deem of higher standing in society and in a position to meet their financial and often social needs. These men include '*boda boda'* riders, touts, and fishermen.

Low economic power also leads to low access to education, as the teenage girls' families lack the financial muscle to cover the cost of education for their teenagers and sustain them through the desired levels and stages of formal education, translating to the inability of these girls to meet their full potential in life (KNBS, 2014). Low socio-economic status directly contributes to a lack of strong role models who can be looked up to for inspiration for bright futures for children and teenagers. Child abuse in diverse forms, from physical, economic, and psychological, to sexual, is rampant in low socio-economic settings (Lawrence, 2004). The exposure to, or even the experience of violence by children often translates to adults who are not fully developed, disconnected from their families and society, and subsequently, with limited capacity to make ideal life decisions (Aidoo, 2016; Clarke, 2015).

2.4 Information related causes of teenage pregnancy

2.4.1 Parental communication

Just like in any relationship and partnership, positive, open, and regular family communication around sex, sexual reproductive health and rights is key to delayed sexual debut, improved uptake of contraception and informed sexual choices (HSRC,2009:35). Open and honest

communication between parents and teenagers fosters a safe environment and directly translates to a reduction in teen pregnancies occasioned by peer pressure and, or poor choices. Studies conducted on parental involvement have majorly focused on the extent parental involvement impacts the academic performance of teenagers while overlooking any possible impact these relationships have on the sexual health and well-being of adolescents. Teenagers with parents who are actively and consistently involved in their life's present better health and life outcomes compared to those whose parents are not (Hill and Tyson, 2009; Jeynes, 2012; Wilder, 2014). To fully understand the importance of parental communication, focus group discussions were conducted in the Western Cape, South Africa, amongst teenagers. Data collected from these FGDs indicated that there was little to no room for open discussions between mothers and their teenage daughters about their sexuality. These meaningful discussions are largely left to peers and the internet, where teenage girls collect all sorts of unrefined data on their sex and sexuality, leading to a distorted understanding of their sex, sexuality, rights, and health. The data collected from the focus group discussions indicated that parents, especially mothers, had a difficult time having conversations about sex and sexuality with their daughters. Instead of open conversations, they resorted to religious anecdotes meant to instil fear in their teenage daughters and deter them from engaging in sex, without getting into the actual details of sex and sexuality. Across the FGDs, it was clear that open and honest communication around sex and sexuality in the African context is taboo, even in instances where parents, and especially mothers, were aware that female adolescents were sexually active. This lack of open and honest communication has been linked to the increase in teenage pregnancy.

2.4.2 Absent parents

Human development studies show that girls attain maturity faster than boys of the same age. This directly translates to girls becoming sexually active earlier than boys their age. With this

in mind, girls who have absent parents, and especially fathers, to guide them in teenage development, these girls end up pregnant, earlier than those whose fathers are present (Nowak, 2003). The absence of a father figure during the early development phases leaves a void in the lives of girls, leading them to easily identify with men who may present as filling the father figure gap and subsequently engage in sex with these men at an early age. This behaviour suggests that such interactions with men are likely to result in a girl's tendency to indulge in risky sexual behaviours (Nowak, 2003). For the holistic growth and development of children, the active presence of parents or guardians is paramount to teaching them values and morals that they will apply throughout their lives. The key role of parents is to teach their children wrong from right and equip them to be steadfast and stand their ground, in the face of day-to-day challenges. Parents also teach their children the power of decision-making and making the right choices, even considering tough choices. In the absence of this guidance, teenagers are prone to make poor life choices, and unfortunately for teenage girls, these poor choices lead to unplanned pregnancies (Wen-Jui *et al*, 2010). Teenagers tend to have a lot of time on their hands, especially when they have busy working parents. This free time provides a rife opportunity for teenagers to explore, both positive and negative traits, including unprotected sex, which leads to teenage pregnancy and other health and social complications (Wen-Jui *et al*, 2010). Parents and guardians offer guidance to their children concerning education and life in general. In the absence of parents and guardians to offer this guidance and direction, children are prone to making poor life choices, influenced by the environment and any external factor that may come their way, with no true north or sounding board to base their decisions against. Children lacking parental guidance often end up with low educational ambitions and rarely excel in school (UNICEF, 2021).

2.4.3 Mass and social media

In addition to peer pressure, the glamourization of teen pregnancy through highly Westernized and modernised media is rife in Kenya. Teenagers are shown as living their best lives as teen moms, and this leads to unrealistic expectations set in the minds of gullible and naïve teenagers. TV shows and social media posts by teen moms portray teen pregnancy, and teen sex, as enviable traits, and easy keys to social acceptance among teenagers, who crave nothing more than to fit in and be accepted by their peers. These shows and social media posts portray children born to teen moms like dolls, playthings even, trivializing the magnanimous effort that is motherhood. Key examples of this deception are the widely televised TV shows *16 and Pregnant* and *Teen Mom*, which are aired to a global audience and viewed widely in Kenya, easily viewed as highly controversial, and misleading to malleable teen girls and boys (Mellsa *et al*, 2014). Diverse and contrary opinions exist concerning these shows; some view them as informative, providing teenagers with information on where to seek sexual reproductive health information and services, while others view them as totally misguiding and misleading as they do not bear the full brunt of teen pregnancy on the table for the adolescents to appreciate. Being at an age where teenagers are not fully emotionally mature or capable of making sound decisions, the shows are largely viewed as a tool to deceive and misguide highly gullible teenagers. This is perceived by many as a gross abuse of power and betrayal of trust by the masses who place the responsibility to provide correct and accurate information to the masses on the fourth estate.

> *"Media has a great influence on teen pregnancy, especially television series such as "Teen Mom" and "16 and Pregnant. These shows often portray pregnancy as a good thing and hide the difficulties associated with pregnancy. As a result, these teenagers are encouraged to become pregnant. Some teenage females become pregnant so that they will be able to drop out of school or force their partners into a deeper commitment. Rebellion is also another reason why some teenagers will become pregnant. To show their independence and deem themselves as having more control over their lives, a teenager may decide to have a child. These programmes glamorize the idea of having a child through the promotion of the youth having a more adult lifestyle, with more*

responsibility and decision-making power" NEWS TRIBUNE "16 & pregnant and teen mom: do these shows hurt or heal" (News Tribune 2012, September 29)

2.4.4 Lack of sex education

The national push to revise national curricula and incorporate gender-sensitive and age-appropriate comprehensive sexuality education has been met with a great backlash, yet this information is critical to equipping teenagers with the right information to understand their sexuality and make informed choices around the same. Completion of education is directly linked to improved health and life outcomes, especially among girls. Young girls who have not completed basic education begin childbearing at a young age, with 33% of those aged 15-19 presenting with pregnancies at their age, compared to 12% noted among those who have a secondary or higher level of education (KNBS, 2019). Cognizant of the fact that teenagers spend over 70% of their time in school, this is the right environment to provide learners with the prerequisite information and tools they need to prevent early unplanned pregnancies. Aside from the provision of information, schools also provide a social safety net, protecting teenage girls from exploitation they may otherwise face if not in school, and reducing the risk and exposure to teenage pregnancy and the compounding health complications.

The sexual reproductive health information provided at school must be customised to respond to the specific needs of teenagers. Times are changing and information that was relevant five years ago will not respond to the needs of adolescents today, therefore, the need to consistently update the available information, to ensure it is easily received by teenagers is critical in the response to teenage pregnancy. The need to include parents in this conversation, as primary caregivers, cannot be understated, as they are the first point of contact with the teenagers. Studies show that parents have largely relegated the role of having sexual reproductive health and sexuality conversations to teachers (NAYS, 2015). Teenage pregnancy conversations must begin with conversations around consent; covering what consent is and its importance in all

sexual interactions, for both boys and girls. A study carried out across 78 secondary schools in the HomaBay, Nairobi and Siaya Counties portrayed a grim picture when it comes to matters of consent; with over 50% of male students and a third of female students noting that when they say no to sex, they mean yes, a grave misunderstanding and misconception of consent and over half of the female students, and over 70% of male students holding the opinion and believe that "protected and consensual sex with someone you love is a good thing" (APHRC, 2017). The contrast in findings indicates a clear knowledge gap among this age group.

> *These inherent contradictions in the responses from nearly 2,500 Kenyan students demonstrate that there was a decided lack of understanding and awareness about sexuality, sexual and reproductive rights, consent and how to best protect oneself against sexually transmitted infection or unplanned pregnancy (APHRC,2017)*

Age-appropriate sexuality education aptly equips teenagers to make the right choices, leading to the full attainment of their potential and the attainment of the best health and life outcomes. The APHRC study covered teachers too and one of the key findings was that out of all four teachers studied across the three counties, three (75%) were teaching comprehensive sexuality education topics to their learners. However, out of the students studied, only 2% noted receiving education around comprehensive sex education (APHRC, 2017). This is a clear indicator of the need to customize and update the information disseminated to learners to ensure it is effective and appropriately responds to the present needs of the learners. A conservative approach to sex and sexuality features largely among different communities across the country when it comes to teenagers; abstinence has always been presented as the only viable way to prevent unintended pregnancies and sexually transmitted diseases and infections. Of the students studied by APHRC, aged between 15-17, a quarter of them noted that they had already had their first sexual encounter, and therefore needed more information on their sexuality to protect themselves and their sexual partners. This presents a situation that calls for all actors to stop burying their heads in the sand and assuming teenagers are not

sexually active, and rather, equip them to ensure they practise safe sex. Studies have shown that presenting limited information and options on preventing teenage pregnancy and contracting STDs and STIs to teenagers has more detrimental effects on their overall health and well-being, and does them no good (APHRC, 2017). Teenagers have, over time, been taught by their teachers to wait till marriage to have sex, however, married teenagers are not well equipped to handle sex and their sexuality, and the impact of the same on their health and well-being. The students studied by APHRC noted that their teachers only told them that sex before marriage was harmful, without providing any clear details or information to demystify the harm they were referring to or providing the students with practical tools to prevent, and/or deal with the harm presented (APHRC, 2017).

Learners are not offered information about available methods of contraceptives, how to use them and where to access them, or crucial components of robust comprehensive sexuality education curriculums or learning modules. Denying learners crucial information reflects on the social conditioning of the communities we live in, but also a gap in the training of teachers, to adequately equip them to support learners (APHRC, 2017). If teenagers are provided with appropriate and comprehensive information on sex and sexuality from the right quarters; teachers, parents, and guardians, they will not need to seek this information from their peers and social media, sources that offer them inadequate and misguided information. With the proper information, teenagers will be well-equipped to make wise informed choices and decisions, leading to a positive impact on their lives (Way, 2014).

2.5 Access to sexual reproductive health and rights products and services

2.5.1 Non-use of and unmet need for contraception

Research shows that equipping young people with information on the correct and consistent use of contraceptives is one of the guaranteed ways to prevent unplanned and unintended pregnancies, and sexually transmitted diseases and infections. Inadequate access to contraceptive information and services is a key barrier to the prevention of teen pregnancies in Kenya. The adolescent reproductive health policy does not explicitly provide for easy access for teenagers, presenting a legal grey area on the matter (MoH, 2014). Statistics indicate that only 10% of public health facilities provide adolescent-responsive and friendly services. Noting that teenagers do not have the financial capacity to access these services and products from private providers, the lack of youth-responsive services prevents a key gap in prevention and response to the teen pregnancy menace. Teenagers do not seek services at public health facilities owing to the poor attitude they receive from the health care providers who believe young people should not be accessing these services and products. This attitude, held by the healthcare providers, regardless of their knowledge of teenage sexual activity presents a barrier in the response to teenage pregnancy (SARAM, 2013). Fear of judgement keeps teenage girls, who need modern contraceptives from accessing the services and products, despite the data that indicates the need. There are 51% of unmarried sexually active girls aged 15-19 and 36% aged 20-24 need modern contraceptives. The gap between policy and practice to ensure access to contraceptive products and services for girls in Kenya must be filled, if we are to effectively address teenage pregnancy as a growing health and social concern (KNBS, 2014).

Teenagers, who are in a transition phase between childhood and adulthood have a high demand for privacy and anonymity. Conversations around sex and sexuality are not openly held in Kenyan homes, and efforts to entrench it in the curriculum have been met with grave backlash.

This has left a huge gap concerning access to correct information and teenagers rely on their peers and digital tools to gather information on sex and their sexuality. The healthcare providers who would be the next best source of this information have been identified as a key barrier to access as they hold biased opinions that teenagers should not be sexually active, nor should they access contraception information, services, and products. Teenagers fear that if they do visit healthcare facilities, the healthcare providers, who are well-known within the community may report their visits to their parents (UNFPA, 2015). This personal bias hinders the provision of information, products and services required to protect already sexually active teenagers from pregnancy and other associated health risks. Critical messaging around contraception has been positioned as family planning messaging, with the teenagers feeling no need to be planning families, hence no need for them to access or use contraception, despite their active sex lives. In some settings, it has become commonplace for mothers to encourage their young daughters to get pregnant to provide them with a child to take care of in the home, regardless of the risks to the teenager or interruption of life (UNFPA, 2015). Kenya has 2.8 million women aged 15-19, with 24% of them, 665,000 having an unmet need for contraception. All these young women in need of a modern contraceptive are sexually active and at risk of contracting a sexually transmitted disease or infection and falling pregnant. The one thing they all have in common is their desire not to get pregnant (Ministry of Health Kenya, 2015). This is compounded by the legal provisions around access to contraception by teenagers, where the Sexual Reproductive Health and Rights bill calls for access to contraception for those above the age of 18, leaving sexually active teenagers vulnerable and susceptible to unplanned pregnancies (Ministry of Health Kenya, 2015).

2.6 Theoretical Framework

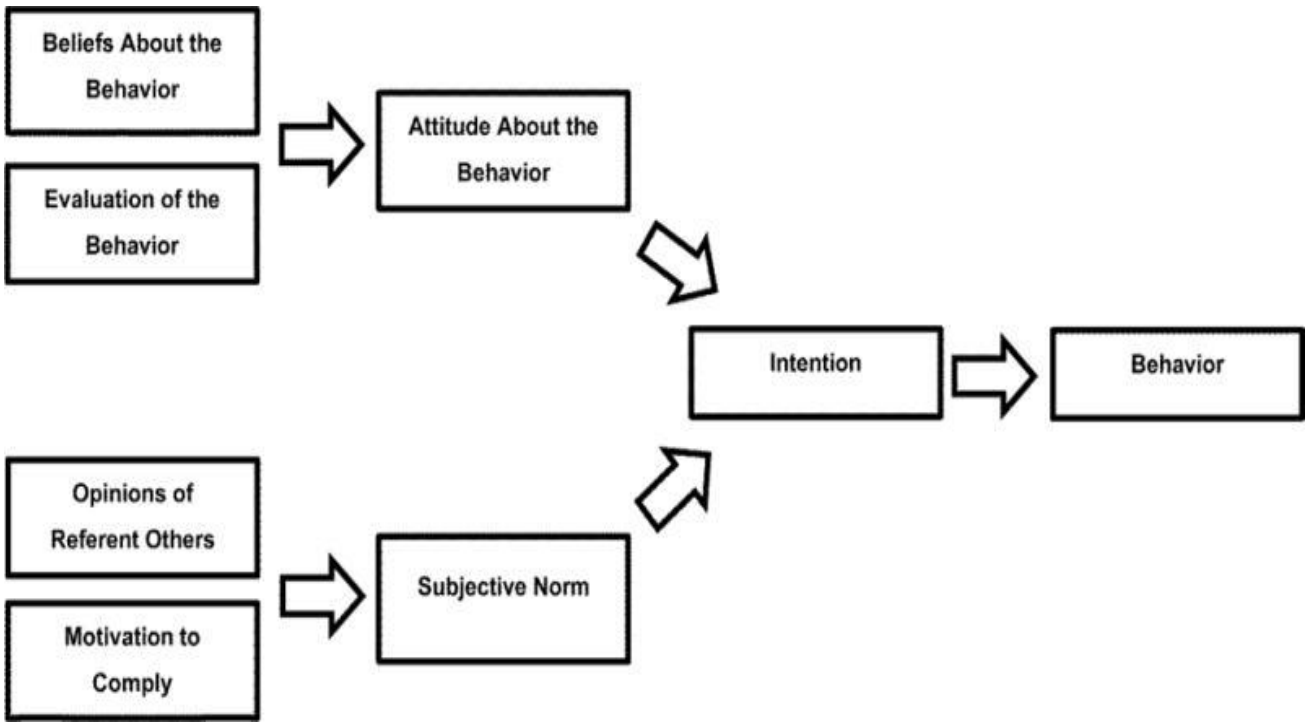
During data collection, analysis and presentation, this study will be guided by the Theory of Reasoned Action (TRA) which was propounded by Martin Fishbein and Icek Ajzen in 1975. The Theory of Reasoned Action assumes that a person is bound to act rationally, in line with their individual attitudes, subjective norms and perceived control over a behaviour. In the real sense, these factors are often not necessarily actively or consciously considered by an individual when they are deciding, rather, are part of the individual' decision-making process. The Theory of reasoned action assumes that when a person is deciding, the decision is not to an extent influenced by their emotions but is fully pegged on rationality. The theory of reasoned action is guided by the principle that a person act based on an intrinsic desire to carry out the behaviour guided by how they feel about the behaviour, their attitude, and how they are socially conditioned to perceive the behaviour, their subjective norms (Fishbein and Ajzen, 1975). The theory of reasoned action focuses on what drives a person to behave the way they do, focusing on the core intention of a behaviour. In the process of identifying the core drivers of behaviour, this theory identifies the in-between for stopping at attitude predictions and therefore enabling the prediction of behaviour, differentiating the intent to do something from the actual act of engaging in the actual behaviour (Fishbein M, 1975). The Theory of Reasoned Action has been utilized to aid researchers predict and explain several health behaviours (LaCaille, 2020).

The selected theory focuses on four main terms, in the effort to predict human behaviour, and the intent to engage in a behaviour: belief, attitudes, subjective norms and intention (Fishbein and Ajzen, 1975). According to Fishbein and Ajzen, a **belief** is a probability that an object has some attribute; used to mean that someone believes an action will lead to a certain consequence. For example, when someone believes that smoking cigarettes will lead to lung cancer, they believe that lung cancer is ultimately caused by smoking and therefore they may

choose to smoke or not to smoke, based on their risk perception related to lung cancer. In the same breath, a person may hold a strong belief that rigorous exercise leads to better health and lifestyle while another may believe the same holds the risk of high injury. These beliefs will determine how the two individuals relate to, interpret, and engage in physical exercise. **Attitudes** are easily defined as positive or negative evaluations of a particular behaviour, and the impact this has on how we engage in a behaviour or respond to it when others engage in it. Our attitudes inadvertently determine the value of, or the weight of the outcome of behaviour, hence guiding the decision whether we engage in the behaviour or not. Attitudes are indicators of what we value, and the magnitude of value we place on things and behaviour (Fishbein and Ajzen, 1975). The Theory of Reasoned Action infers that attitude is in essence, a direct result of our beliefs. For instance, if a person believes strongly that exercise has a positive impact on their bodies and lives, they will engage in exercise, while the reverse is true. Fishbein and Ajzen (1975) define attitude as "a disposition to respond favourably or unfavourably towards a psychological object" (Encyclopaedia of Applied Psychology 2004, Page 127). Subjective norms are defined as the total of the beliefs close to a person, and whether they would approve or disapprove if one engaged in a behaviour. If we take the exercise example, an individual will engage in exercise, or not, if their mother, father, spouse, doctor, or best friend want them to exercise and think exercise is good for them. Descriptive norms are described as the total of what an individual thinks others want them to do, whether this assumption may not be in line with the person's belief. If an individual believes that many people engage in rigorous exercise, they may opt to begin exercising rigorously, though the belief they hold may be false. Subjective norms are designed by society and are a function of the normative beliefs of a society. These beliefs govern how an individual engages with others within their society. Descriptive norms entail a person's perception of what will be perceived as right or acceptable by society while subjective norms are a function of the normative beliefs a society entails that

the people who are important to someone and govern a person's life. Each of these people has two key psychological values (Fishbein and Ajzen, 1975) normative belief, meaning whether a person believes others want them to engage in an activity or carry out an action and motivation to comply, meaning the intensity of a person's desire to undertake an action their belief someone important to them wants them to undertake. Intention refers to the willingness and preparedness of a person to undertake an action or behaviour. It is weighted by a measure of their likeliness to engage in or undertake a specific behaviour.

The Theory of Reasoned Action can be described diagrammatically as elaborated below:



2.7 Relevance of the Theory

The theory of reasoned action is ideal for this study. This is owing to the premise that the theory delves into the root determinants that drive behaviour leading to teenage pregnancy from the perspective of the target audience, those primarily impacted by the scourge, the teenagers, from their personal lived experiences and perspective. Their experiences will be outlined against a backdrop of societal expectations and pressure, especially in the African context where such teens are often ostracised from society and branded as deviants, with no regard for the circumstances of factors leading to their pregnancy. Aside from being ostracised, teen mothers usually receive minimal to no support, as they are deemed as having lost the potential to attain their goals or aspirations (Human Rights Watch, 2018). When the theory of reasoned action is compared to other theories, it holds a higher comparative advantage as it significantly captures relevant data relating to the variances seen concerning teen pregnancy and the level of risk perception attributed to unprotected sex among this age group (Koniak-Griffin et al., 2003). The application of the theory of reasoned action provides empirical data, through observation and application, that presents better ground to prevent and respond to teenage pregnancy by capturing information such as the age of sexual debut and the use or non-use of contraceptives.

The application of this theory will aid us in unpacking the correlation between adolescent attitudes and their behaviour, providing in-depth details that will enable us to unpack the drivers of teenage pregnancies within the study area. This theory will help us unpack the drivers of behaviour by focusing on personal attributes, attitudes, characteristics, and external influences, including role models and influences around a person. Parents, friends, partners, acquaintances, and colleagues greatly influence a person's subjective norms, as extensive interaction, and exposure lead to borrowing and rubbing off behaviours and characters from one person to another. The theory of reasoned action has not been extensively utilized to study

sexual reproductive health and particularly, teen pregnancy and teen sexual behaviour. Therefore, the findings collected from this study will provide critical information that will guide the development of targeted interventions and policies geared towards addressing the teenage pregnancy menace within the study area.

CHAPTER 3

METHODOLOGY

3.1 Introduction

The methodology section covers details on the proposed study site, study design, encompassing the prospective study population and unit of analysis, the proposed sample size and sampling procedure, data collection, data analysis and the ethical considerations that will be applied throughout the study.

3.2 Research site

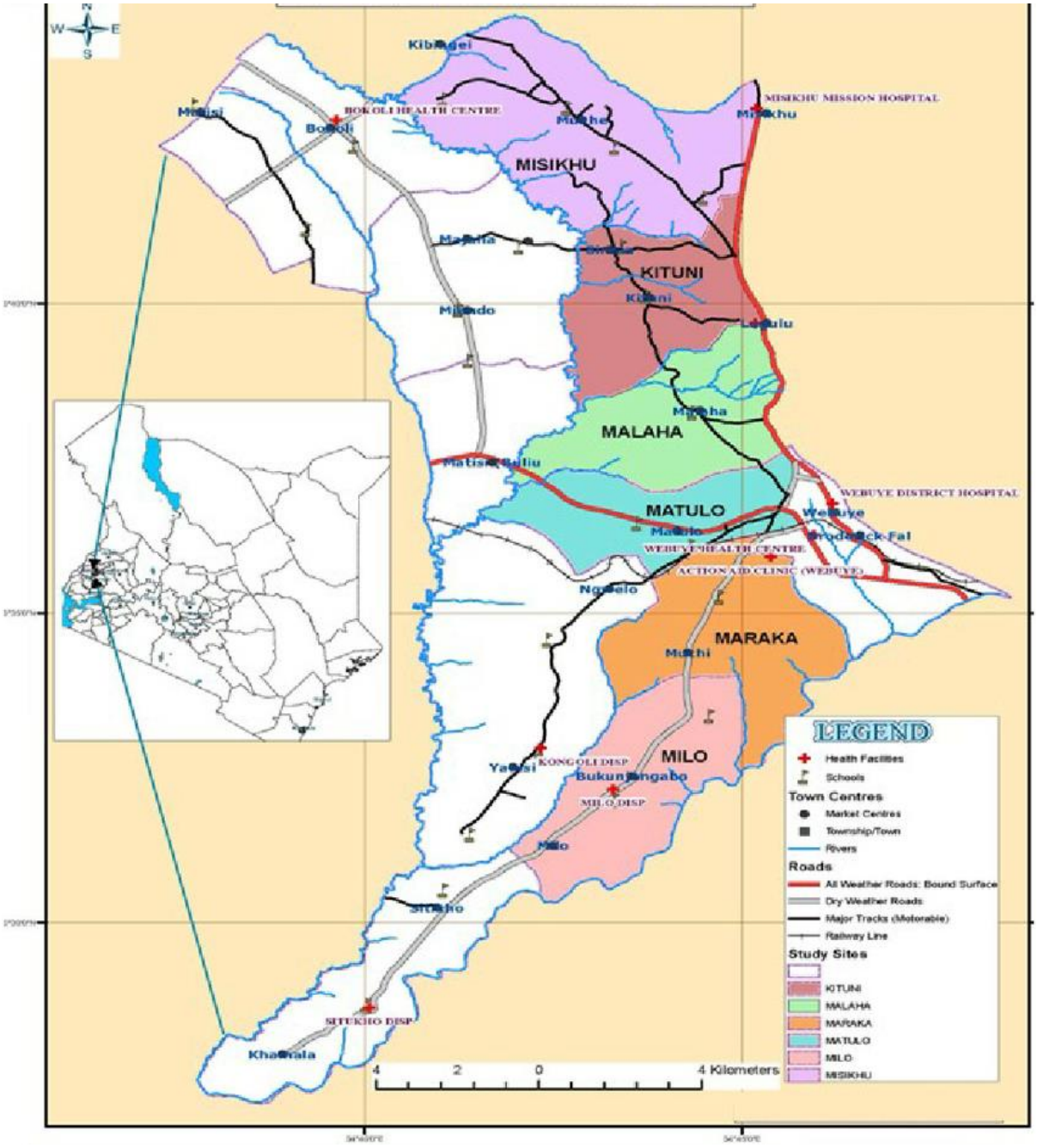
The study area was Webuye West Sub-County, Bungoma County (Map 1). Webuye West Sub-County is one of the 12 Sub-Counties within Bungoma County, located in the Western region of Kenya, lying at an altitude of 0^{o} 37' 0'' North, 34^{o} 46' 0'' East. The temperatures within the county vary from 0^{o} to 32^{o} centigrade and there are two key geographical features: River Nzoia and Chetambe Hills. Just like other regions in Kenya, Webuye West Sub-County enjoys the traditional long rains that fall from March to August and the short rains that span from August to October, annually. These steady climate patterns have been affected by global warming, leading to reduced volumes of rainfall over the two periods. Webuye is mainly inhabited Bukusu ethnic group and the Abatachoni.

Webuye West Sub-County occupies a total area of 242.6 square kilometres. The 2019 population census placed the population at a total of 152,515 people; 74,180 men (48.6%), and 78,331 women (51.4%), of these, 44,077 are adolescents and teenagers, the target population for this study (KNBS, 2019). National population projections indicate that Bungoma County has a total teenage population of 244,695; 117,407 males and 116,803 females. This gives a male-to-female ratio of 0.96 which compares favourably with the national ratio of 0.98.

Agriculture is the main economic activity of the Sub-County, accounting for over 75% of the people. Apart from livestock keeping, the local people grow both cash and food crops such as maize, coffee, sugarcane, vegetables, sunflower, beans, bananas, millet, and potatoes (County Government of Bungoma, 2019). The study sought to identify the main determinants of teenage pregnancies within Webuye West Sub County, Bungoma County Kenya Participation in the study was voluntary and there were no financial or other direct accrued by any respondents.

Figure 1 Map of Kenya showing the location of Bungoma

Figure 2 Map of Webuye West Sub-County



3.3 Study design

The study employed a descriptive study design and data was collected to respond to the three key research objectives. Qualitative data collection methods applied were in-depth interviews, focus group discussions and key informant interviews. Using all three data collection methods was key in the triangulation of the collected data.

3.4 Study population and unit of analysis

The study population comprised all teenage girls aged 18 years and above who gave birth before attaining the age of 18 years. The unit of study in this study was therefore individual teenage girls aged 18 years and above who self-reported being teen mothers or who were pregnant at the time of the study. Teenage pregnancy disproportionately affects teenage girls hence the focus on them. The target respondents were a mix of teenagers both in and out of school, to aid in understanding the effect of early unplanned pregnancies on girls' educational and life outcomes. The study inadvertently tried to understand the impact and effectiveness of the national return to school policy that presents teenage mothers with an opportunity to reintegrate into schools and resume their education as soon as they deliver.

3.5 Sampling procedure and sample size.

Non-probability-based purposive sampling was applied for this study to purposively select ideal respondents as the criteria were set as teenage girls aged 18 and above who self-reported pregnancy in their teen age or were pregnant at the time of the study. The study site has a total population of 152,514 people (74,180 male; 78,311 female and 4 intersex). The sample size for this study was 40 informants in line with Anderson *et al.* 2010, for a population of above 10,000, 1% was taken to calculate the sample size. Thirty (35) key primary teenage informants were interviewed, and five (5) key informants were engaged to offer additional insights into the study.

3.6 Data collection

The use of three methods; in-depth interviews, focus group discussions and key informant interviews, was key in the triangulation of the data collected, to respond to the research questions outlined. The study began with in-depth interviews with teenage girls aged above 19. The inclusion criteria for their selection included a female resident of Webuye West Sub County who has given birth while below the age of 18 years and resident of Webuye West Sub County. The in-depth interviews provided insights into the circumstances of the girls that predisposed them to teenage pregnancies, as well as increased their vulnerability to unintended pregnancy. Key informant interviews were then undertaken to build on the insights shared by the teenage girls. Focus group discussions with secondary respondents were critical to highlight the perceptions and beliefs of the community members around the girls, concerning teenage pregnancy. Consent was sought from all respondents aged 19 and above, while mature minors heading households, and aged below 18 provided an accent to engage in the study. Informants were engaged at the Chief's camp, church compounds and at their homesteads for those who felt more comfortable engaging there. Data collected was stored on password-protected project tablets accessed by the primary and secondary researchers only

3.6.1 In-depth interviews

Thirty-five informants were engaged in face-to-face interviews. The principal researcher engaged the aid of a research assistant to collect the data, in line with the outlined questions set out in the interview guide. The responses were collated and documented in real-time by the researcher and research assistants jotting down notes. In instances where required and consent is offered, recorded on digital devices for transcribing. The interviews were conducted primarily in Swahili and Luhya. English was applied where informants were comfortable with the language. The use of the three languages did not in any way negatively impact the quality of the findings of the study. Each in-depth and key informant interview took between fifteen

to thirty minutes. The interviews were conducted as outlined: five at school compounds, seven at the local church, two at the community health centre, one at the chief's camp and fifteen at homesteads. The In-Depth Interview Guide (Appendix IV) was used to collect data.

3.6.2 Focus group discussions (FGDs)

One of the data collection methodologies that were applied to collect diverse opinions of the study respondents, especially covering their perceptions, beliefs, opinions, and attitudes towards teenage pregnancy was focus group discussions. The focus groups comprised between six to eight participants selected from the pool of key informants to offer additional insights on teenage pregnancy. Each focus group discussion was facilitated by the principal researcher in Swahili, with the research assistants providing translation to Luhya, when required and taking down key discussions. Each focus group discussion took between one to one and a half hours. The researcher carried out four sessions: with parents at a local school compound, with teenagers at the local church, with community gatekeepers' chiefs' camp and with health care providers at the local health facility within the study area. With consent, the discussions were audio recorded and later transcribed verbatim. The focus group discussions were facilitated by the principal researcher and a focus group guide (Appendix II) was used to collect data.

3.6.3 Key informant interviews (KII)

The research engaged five key informants, who were selected from within the study area forming part of the members of the community with knowledge on the topic under study. The key informants comprised one healthcare provider, a religious leader, a social development worker, a community leader, and a civil society organization representing key stakeholders working to address teenage pregnancy within the study area. The key informants provided additional and critical insights into teenage pregnancy from the perspective of persons who are impacted by the issue; parents must provide for their children and grandchildren; community

gatekeepers must provide social support and protection to teenagers who get pregnant and health care providers are presented with the additional strain on the health care system to provide maternal services to a group of additional health care recipients. The interviews were conducted at the chiefs' camp and took between thirty to forty-five minutes each. The Key Informant Guide (Annex III) was used to collect data.

3.7 Data processing and analysis

The researcher collected and collated data from all respondents and transcribed this information verbatim. The emerging concerns and -cross-cutting issues were clustered to ensure a systematic and progress-responsive approach to the analysis process. Information and data received and recorded in the local language were first translated into English by the researcher and the assistant researcher and transcriptions were compared for consistency. The data was then analysed thematically using the Nvivo 11 software to organize the data collected and identify cross-cutting responses from the data collected, aiding in analysis.

3.8 Ethical considerations

Before embarking on this research, certain ethical considerations were undertaken to ensure that the study was up to par with research ethics and principles. Ethical approval was received from the National Commission for Science, Technology, and Innovation (NACOSTI) under licence number NACOSTI/P/22/22229. The participants were informed that the core intent and purpose of the study for academic purposes and feedback shared and recorded by the researcher was used for this sole purpose, and in essence, was not shared with any other parties. Consent to engage in the study, and to record their responses was sought. Confidentiality and anonymity were strictly observed throughout the study, and all measures taken to reinforce it during and after the study was concluded. The participants were informed of the opportunity to ask questions and seek clarity regarding any components of the study that may be unclear to them.

Lastly, the participants were informed of their free will to discontinue engagement in the study at any point, with no repercussions whatsoever. This notwithstanding, the researcher requested their cooperation, and the respondents were at liberty to make their own choices and decisions on whether to engage in the study or not.

Study respondents were protected by keeping the information given confidential and accessible to the researcher only. The data collected was kept under lock and key on a password-protected computer, for digital files, and in a password-secured briefcase, for field notes and tape recorders. The researcher ensured that the information about particular individuals was not disclosed, or their identity made known. Instead identifying numbers, codes, third parties or pseudo names were used instead of the real names to protect the identity of the respondents. Statistics and data indicate that engagement in social science studies results in more psychological harm than physical harm (Mugenda, 2006). This was discussed extensively with all respondents to ensure they understood the protections accorded by engaging in this study. The researcher ensured that embarrassing questions, threatening statements, expressing shock or disgust about the data received, or coercion of respondents to say what they do not believe was avoided at all costs. The researcher ensured no harm to the respondents by avoiding personal and potentially embarrassing questions.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

4.1 Introduction

This study on determinants of teenage pregnancy was conducted in Webuye West Sub-County, Bungoma County. This chapter will cover the demographic characteristics of informants and key findings from the study. It was important to outline the demographic characteristics of the informants as these gave insights into the mind shifts attributed to age, level of information and decision-making agency possessed by specific informants who self-reported pregnancy in their earlier teenage years.

This chapter will delve into the key socio-economic determinants of teenage pregnancy, covering cultural factors that are key to society and inadvertently have an impact on teenage pregnancy within the study area. The chapter will also highlight the level of information, including the key sources for teenage girls and the level of accuracy of the information they access and how this impacts their personal decisions, leading up to the decisions they make concerning their sexual reproductive health and rights. The chapter will also investigate the availability and access to reproductive health and rights products and services within the study area and the bearing this has on teenage pregnancy.

4.2 Demographic Characteristics of the Respondents

This section covers the demographic characteristics of the respondents, including age, gender, marital status, and the number of children.

4.2.1 Gender of Respondents

The teenage informants were all female, and the key informants were asked to indicate their gender. The results were as shown in Table 4.1.

Table 4.1: Gender of Respondents

From the findings collected 88% (35) of teenage girls were engaged in-depth interviews. The key informants engaged were representative of both genders; 40% (2) male and 60% (3) female to ensure the gender perspective on teenage pregnancy is represented. Engaging the male informants was key in this study as it provided insights into the socio-economic perspective of the male gender on their role in the prevention and response to teenage pregnancy within the study site.

Gender: **In-depth interview respondents**

Teenagers	**Number**	**Percentage (of target)**
Female	35	88%
Key Informants		
Male	2	40%
Female	3	60%

4.2.2 Age of Respondents

The respondents were required to indicate their age. The informants engaged in the in-depth interviews aged 18-19 aided the researcher to collect data on teenage pregnancy from teenagers who were within the primary age bracket of the population affected by teen pregnancy as well as hear from those who self-reported teen pregnancies; these were the informants aged above 19. The data collected from these two age brackets was critical in the formation of inferences and presentation of recommendations for the study. The results of the age of the informants are as summarised in Table 4.2.

Table 4.2: Age of Respondents

In-depth interviews	**Frequency (N=35)**	
18-19 years	20	57%
19-30 years	15	43%
Key Informants	F (N=5)	
20-30 years	1	20%
31-40 years	1	20%
Above 41 years	3	60%

4.2.3 Marital Status

The key informants were required to indicate their marital status. The marital status of the informants was useful in identifying whether teenage pregnancy had a bearing on the marital prospects of the teenagers within the study site. The findings were as shown in Table 4.3.

Table 4.3: Marital Status

I-depth Interviews	Frequency (N=35)	Percentage
Married	17	49%
Unmarried	18	51%
Key Informants	Frequency (N=5)	Percentage
Married	4	80%
Unmarried	1	20%

4.2.4 Number of Children Sired

The key informants were required to indicate the number of children they have. The results show that 40% of the respondents had 0-2 children, 40% had 3-4 children and 20% had more than five children. The results were summarised in Table 4.4.

Table 4.4: Number of Children

Key Informants	Frequency	Percent
0-2	2	40%
3-4	2	40%
Above 5	1	20%
Total	**5**	**100%**

4.3 Socio-economic determinants of teenage pregnancy

One of the informants indicated their understanding of teenage pregnancy in line with the provisions of the Constitution of Kenya that classifies teenagers as individuals who are aged below 19 years. The informants noted that they believed an individual aged below 19 years is a teenager and when such individuals become parents it is referred to as teenage pregnancy.

> *'Teenage pregnancy refers to when young individuals of below 18 years of age become parents'* ***(KII #2)***

In the FGDs, the teenagers were asked to indicate their understanding of teenage pregnancy. They indicated that teenage pregnancy is when one gets expectant when below the age of eighteen years. Others indicated that teenage pregnancy is when a girl gets pregnant while in primary or secondary school.

> *'I got pregnant when I was in standard seven; I am an example of a teenage mother'* ***(FGD Respondent, 18 years old)***

4.3.1 Low socio-economic status

The teenage informants were asked to indicate the factors that directly contribute to teen pregnancy. The responding teenagers indicated that the key factor leading to early and unintended pregnancy is poverty. They noted that they come from very poor family backgrounds. The respondents unanimously indicated that the inability to meet their basic needs and specifically food and clothing leaves them vulnerable to advances by persons who have disposable income to spare. Most often than not, these individuals of higher economic standing will demand sexual favours in exchange for cash. The teenagers who lack bargaining power for safe sex, and survival sex in general, are forced by circumstances to engage in unprotected sex that leads to pregnancies. The informants noted that their guardians lack financial resources to afford as little as Kenyan shillings one hundred to buy food or sanitary pads, during their menses.

> *My family has a small source of income which is only used to provide meals. There is no extra money for me to spend on myself'* ***(In-depth interview respondent)***

The key informants indicated that lack of school fees by parents leading to school dropout contributes to a low level of agency to make informed decisions concerning sexual reproductive health and rights, and early and forced marriages, as a means of survival. The respondents also noted that survival sex through commercial sex work is a determinant of teenage pregnancy; teenage girls are forced by circumstances to engage in sexual intercourse with members of society who are perceived as having a financial upper hand such as sugarcane farmers, factory workers, 'boda boda' riders, matatu drivers and matatu touts. Across all four focus group discussions, respondents noted that poverty and low financial power present a compounded challenge to teenagers. The need to survive supersedes any societal norms related to sex and sexuality, leaving teenagers from financially disenfranchised backgrounds susceptible to sexual exploitation for survival.

*I am unable to provide food for my family, for at least one meal a day. My daughter will bring food home. I am too embarrassed to ask where she has got it from, but sadly, I know (**Parents FGD respondent**)*

4.3.2 Peer Pressure

The respondents also noted that peer pressure is not generally about having sex or having a boyfriend, it also involves getting certain benefits from boyfriends like money, snacks, personal items, and clothes. Other respondents' indicators indicated that forced marriage is also a cause of teen pregnancy. They indicated that parents force them into early marriage so that they can benefit from that marriage by getting support from their in-laws. Another driver of teenage pregnancy is sexual abuse like rape. The teenagers indicated that they are forced to engage in sexual activities by older individuals around them.

Some of the respondents added that peer pressure contributes to teen pregnancy out of the desire to do what their peers are doing in a bid to fit into their social groups or cliques. This came across as a key concern and determinant of what we are doing as the main problem. They noted that if their friends have boyfriends, they also desire to have a boyfriend to fit in their category. Further, if their friends get financial benefits from their male friends, they also desire to be like them.

*'If my friend has a boyfriend, I also want to have a boyfriend. At times when my friends have boyfriends, I may also be influenced to have a boyfriend due to the peer pressure to fit in' **(In-depth interview respondent)***

4.3.3 Alcohol, drugs, and substance abuse

Alcohol consumption, especially of traditional and illicit brews available in the community was attributed to sexual and gender-based violence perpetrated against teenage girls. This was often noted to happen during socio-cultural events such as night vigils "disco matanga" and

wedding ceremonies where alcohol is readily available and parental controls are lax. Some of the in-depth interview respondents noted they had often indulged in the consumption of the drinks available at traditional ceremonies. They noted that they were able to indulge as there was minimal, often no parental supervision at these events and often the alcohol and drug abuse was a result of peer pressure, not out of choice or their own free will. Consumption of alcohol and drugs leads to reduced inhibitions and lowers one's ability to make sound, informed choices concerning bodily autonomy and engagement in premature sex.

During the community gatekeepers focus group discussion, the chiefs' representative present noted that despite the national ban on events such as 'disco matanga' the policy is difficult to implement as the practice is entrenched in the culture of the community they are serving. They noted that the challenge they are dealing with is striking a balance between culture and socially sound practices within the study site.

4.3.4 Social ageing

The focus group respondents noted that the community accords respect to mothers, as prescribed by the Luhya, and by extension, African culture. This perceived status and lack of clarification of this cultural norm leads young people to believe they will be accorded this respect once they get pregnant. For the teenage respondents engaged in key informant interviews, this denies them their childhood and presents responsibilities they are incapable of handling adequately. This presents a barrier to the development of teenagers as they are pushed to embrace adulthood, while still children themselves. This social ageing curtails the natural growth, progression, and development of teenagers.

> *"I gave birth at 17 years of age. My parents told me that I had become an adult and was responsible for another human being. I had not completed secondary school and*

had to drop out of school as there was no one to watch my child. When I was young, I dreamt of being a doctor, and now, my dream is just that, a dream."
(FGD participant, 28 years old)

4.4 Information-related determinants

The in-depth interview respondents noted that they were aware of the information offered on physical and emotional well-being, sexual and gender-based violence, prevention, care and treatment for HIV and free condoms. Information relating to the correct and consistent use of condoms and the availability of other forms of contraception, including legal provisions that guide access and use of contraception was limited among the participants of the focus group discussions. The key informants were asked to indicate where they, or any young person they know, access sexual reproductive health information, products, and services. They indicated that sexual reproductive health information is accessed in schools, health centres, social media, the church and teenage forums organized by CSOs and other organizations working in the community. The key informants aged above 30, who self-reported teen pregnancies, noted that they accessed information, products, and services later in their lives when they were already pregnant.

"The information that was shared in the group discussion is so critical and useful; If only it had been shared with me when I was younger, I would have made informed decisions about my life."
(KII respondent, 35-year-old mother of three)

4.4.1 Mass and social media

The in-depth interview respondents noted that media like pornography and sexual content in videos, song lyrics, movies, or social media sites, are viewed to impact young persons into engaging in sex or viewing sex as advantageous. The respondents noted that most young people begin watching such content or seeking out information on social media because of peer influence. This is a result of fear of speaking to parents or elders about topics considered taboo

such as reproduction, sex, and relationships. This fear forces young people to turn to digital media channels for advice and guidance on their sexuality. Most often than not, the information they access is not verified and leads to poor decision-making.

> *'When I had my first menses, I did not know what was happening. I googled and the first answer was an aborted pregnancy. I was so scared I almost collapsed' (**Teenage girls FGD respondent**).*

4.4.2 Information on sexuality education

The participants also indicated the need for the provision of abstinence education. Abstinence is the decision not to engage in sexual activity to avoid pregnancy and other sexually transmitted diseases and infections. When provided with appropriate sex education and information, many teenagers make the conscious decision to postpone having sex until they are older. This is a responsible decision that young people follow without being swayed by peer pressure as they are capacitated to make this individual decision.

The teenage respondents noted that the art, including but not limited to plays, community radio and community talk shows, is a powerful tool that can be utilized to sensitize the community. These platforms will provide a space for young people to speak openly and freely about the challenges they experience while presenting an avenue for positive utilization of their time, reducing the amount of idle time they have on their hands to engage in negative norms. The participants also noted that art can be used to dispel stigma and negative myths about contraceptives and sexual reproductive health and rights and increase awareness of the importance of correct and consistent use of contraception.

> *"With the support of UNICEF and other development partners, we have instituted an arts and culture program at the community centre, in collaboration with the administration. Our hope is that the young people will continue to engage socialistically, as they have thus far, so that we can use the centre as a channel to*

pass positive messaging and offer a safe space for the young people to express themselves and grow in their youth."
(Clergy, KII respondent, 32 years old)

4.4.3 Open parental communication

The focus group discussants were asked to indicate if there were any means of curbing teenage pregnancies within Webuye West Sub-County. They indicated that community care and responsibility to keep girls in school, parental and community involvement to openly discuss sexual and reproductive health matters, as well as offer counsel to children without fear, can be key to curbing teenage pregnancies. Participants reiterated the need for parental and learner information on the impacts of teenage pregnancy on the health and well-being of young girls as well as reinforced information on the responsibilities associated with teenage pregnancy. Creating positive relationships with children was noted as a step in curbing teenage pregnancy; Children who have a positive parent-child relationship are more likely to be happy, confident, and able to make wise choices and decisions about their lives, bodies, and sexuality.

The respondents noted that social norms can be leveraged to address teen pregnancy. They indicated that one of the norms that can be deconstructed and used positively is the forbidden discussion of sexual matters between parents and their children. They indicated that parents feel that it is taboo to discuss sexual matters with their children and assume that they will learn from somewhere else. This has led to an increase in secret, ill-informed sexual practices among young people. Hence, this social norm can discourage, and parents encourage, to have a discussion of sexuality with their children. The social norm on sexual relationships is viewed negatively and frowned upon by society. Parents react negatively when they discover their teenagers are engaged in sexual relationships. What is required is for the parents to open up to their children and have a discussion on sexual matters and reproductive health. Sexual norms

are strongly gendered, and social sanctions against pregnant girls are harsher than those against the men and boys who make them pregnant.

4.5 Access to sexual reproductive health and rights products and services

The key informant interview respondents note that they had knowledge of and access to reproductive health products and services after they had fallen pregnant. Male respondents in the parents' focus group indicated that they are not sure because they had never accessed sexual reproductive health services and products. They added that their wives had not indicated if they were using any of the reproductive products available for family planning. The teenage focus group informants indicated that sexual reproductive health services and products were available at their schools. They indicated that they learn about sexual reproductive health through lessons offered by certain teachers. When these teachers leave the school, then they have no formal source of this information as sexual reproductive health is not part of the formal school curriculum.

The Key informants were asked to indicate the sexual reproductive health services and products they were aware of were limited to male condoms and the morning-after pill. The discussants noted the need for health system support and strengthening to improve the quality of health services offered at the available health facility. This includes ensuring the facilities are well equipped and stocked with relevant products, and providers are well trained on the provision of adolescent and youth-responsive health services to encourage positive health-seeking behaviour among young people. The key informant respondent representing civil society and other actors highlighted the need for continuous legal and policy sensitization among parents and teenagers, both boys and girls, to increase the understanding of provisions that protect young people. This will equip parents and guardians to better support young people

concerning their sexual and reproductive health and right's needs, with a specific focus on teenage girls who are the most disproportionately affected by teenage pregnancies and other sexual violations.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The study sought to explore the socio-economic and information determinants of teenage pregnancy in Webuye West Sub County, Bungoma County Kenya. The study particularly sought to ascertain that peer pressure, social media and household poverty are key determinants of teenage pregnancy in Webuye West Sub County; correct information on sexual reproductive health and rights positively correlates to teenagers in Webuye West Sub County and access to quality reproductive health care services and products influence teenage pregnancy in Webuye West Sub County. From the data collected, it was indeed affirmed that there are socio-cultural, information related and access to products and service determinants of teenage pregnancy in the study site.

5.2 summary

The study found that there was a basic understanding of the fact that an individual aged below 18 years is a teenager and therefore when these individuals become parents it is referred to as teenage pregnancy. The study found that the key socio-economic and information determinants of teenage pregnancy are low socio-economic status; poverty and peer pressure that compounds cross-cutting factors that create a ripe environment for teenage pregnancy. Some of the cross-cutting factors that came out strongly from the study include alcohol and drug abuse, sexual abuse, poor child-parent communication, sexual pressure from peers, unsupervised access, use of social media as an information source and lack of age-appropriate sexuality education.

5.3 Conclusions

Teenage pregnancy is a real socio-economic concern in Webuye West Sub County, Bungoma County. However, there are tools at the disposal of the community to address and curb the challenge. The study identified poverty and peer pressure as key determinants of teenage pregnancy as they predispose teenagers to vulnerabilities beyond their agency to comprehend and make informed decisions. The study underscored the need for present parenting in the community and active parental involvement to address the developmental and emotional needs of teenagers, thus ensuring they are well nurtured and moulded into responsible members of society.

The study also identified a lack of age-appropriate sexuality education as a key determinant of teenage pregnancy as young people are left to their own devices to access information on their sexual reproductive health and rights. The study found that there is the availability of basic sexual and reproductive health information, products and services provided in schools and health facilities within the community. Therefore, the study concludes that there is a need for the provision of age-appropriate comprehensive sexuality education for teenagers to empower them to make informed decisions and choices concerning their sexual and reproductive health.

The study identified social norms as a strong tool that can be leveraged to address teenage pregnancy when deconstructed. These include norms such as those that intimate that sexuality is a forbidden discussion between parents and their children, norms on sexual relationships viewed negatively in social and sexual norms that are strongly gendered and place sanctions against pregnant girls, presenting harsher social penalties on girls than the men and boys who engage in sexual intercourse with the girls.

5.4 Recommendations

The study recommends the design of programmes, through the utilization of art, that pass positive messages among teenagers in the community to promote positive engagement and reduced risk to exposure and indulgence in negative norms such as unprotected sex that contribute to teenage pregnancy. The study further recommends the development of community-responsive economic empowerment programs that can contribute to the financial development and improvement of the community, especially among parents, empowering them to provide basic needs for their children and in essence, contribute to the reduction of vulnerabilities faced by teenage girls that lead to teenage pregnancy.

The study also recommends increased parental involvement in the lives of teenagers, providing correct and age-appropriate information on sexuality, and empowering and capacitating teenagers to make informed decisions concerning their sexual health and well-being. The study further recommends the provision of age-appropriate sexual reproductive health and rights information to young people to equip them and increase their agency to make sound decisions, choose when and with whom to have sex, as well as empower them to negotiate for safe sex.

The study additionally recommends the need to continuously improve the capacity of healthcare providers to address the challenges faced by young people with respect to accessing health services and products. To ensure this is realized, the study recommends the allocation of adequate resources to ensure health facilities are functional and well-stocked.

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APPENDICES

Appendix 1: Consent Form

Investigator: Mercy Mwongeli

Introduction

My name is **Mercy Mwongeli** from the Institute of Anthropology, Gender and African Studies, University of Nairobi. I am conducting a social study on the **DRIVERS OF TEENAGE PREGNANCY IN WEBUYE WEST SUB-COUNTY, BUNGOMA COUNTY, KENYA.**

Purpose

This study seeks to understand the causes of teenage pregnancy in Webuye West Sub-County, Bungoma County, Kenya.

Procedure

If you consent to participate in this social study, a face-to-face in-depth interview will be conducted by the researcher. The nature of the questions will centre on drivers of teenage pregnancy, as well as some general questions on the demographic characteristics of the respondents engaged.

Risk/Discomfort

There is no risk attached to participating in this study. However, you may experience some discomfort owing to the sensitivity of the subject matter. The researcher guarantees that the interviews will be conducted privately, at the convenience of the respondents, to ensure confidentiality is maintained at all times.

Benefits

There are no benefits attached to engagement and participation in this study, but in the event a respondent has questions, the researcher will be on hand to respond and allay any fears or concerns held by the respondents The findings of this study will serve to increase the knowledge pool on the drivers of teenage pregnancy within the study area.

Confidentiality

Confidentiality will be always maintained. There shall be no mention of names or identifiable details of respondents in any project related documents and those emanating from the study.

Compensation

There shall be no compensation for participation in this study.

Volunteerism

Participation in this study is fully on voluntary basis. There shall be no forms of coercion to participate for any respondents who wish not to, at any point of the study. Respondents are free to withdraw from the study at any point, however, a kind request for your participation is sought and highly appreciated.

Contact persons

In case of any questions regarding the study, kindly contact the researcher, Mercy Mwongeli via telephone number +254726922231 or supervisor Prof Tom Ondicho via mail at tondicho@uonbi.ac.ke.

Your participation in this study will be highly appreciated.

I……. hereby willingly and freely consent to participating in this study. I acknowledge that thorough explanation of the nature of the study has been shared with me by **Ms Mercy Mwongeli** and I clearly understand that my participation is fully voluntary, towards the furthering of this academic endeavour.

Signature …… Date…….

Signature of researcher……Date……...

Appendix II: Focus group discussion guide

Background Information

Age

Gender

Classification (profession/expertise)

Knowledge assessment

What is your understanding of teenage pregnancy?

What factors directly contribute to teenage pregnancy?

What social norms can be leveraged to address teen pregnancy?

Are sexual reproductive health information, services, and products available and accessible to adolescent girls?

Thank you for your participation.

Appendix III: Key informant interview guide

Background information

Age

Gender

Marital status

Number of children

Age at first child

Knowledge assessment

What is your understanding of teenage pregnancy?

In your opinion, what are the key determinants of teenage pregnancy?

What sexual reproductive health information, services and products are you aware of?

What sexual reproductive health information, products and services are accessible to young girls within your community?

Where do you, or any young person you know, access sexual reproductive health information, products, and services?

Are there any means of curbing teenage pregnancies within Webuye West Sub-County?

Thank you for your participation.

Appendix IV: In-depth interview guide

Background information

Age

Gender

Marital status

Number of children

Age at first child

Knowledge assessment

What is your understanding of teenage pregnancy?

In your opinion, what are the key determinants of teenage pregnancy?

What sexual reproductive health information, services and products are you aware of?

What sexual reproductive health information, products and services are accessible to young girls within your community?

Where do you, or any young person you know, access sexual reproductive health information, products, and services?

Are there any means of curbing teenage pregnancies within Webuye West Sub-County?

Thank you for your participation.