

**SOCIO-DEMOGRAPHIC AND HEALTH CONSEQUENCIES OF
ADOLESCENT SEXUALITY AND FERTILITY IN KENYA.**

BY

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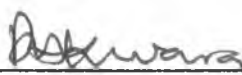
DECLARATION

This research project is my original work and to the best of my knowledge, has not been presented for a degree in any other University.

Signature 
J.N. Kimani

This project has been submitted for examination with my approval as the University Supervisor.

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DEDICATION

To my husband J. N. Kimani, my Sister Wairimu and my children Kimani and Wanjiku, for perservering when the going was tough.

ABSTRACT

The main objective of the study was to find out the extent to which adolescent fertility affects the socio-demographic and health scenario in Kenya. The study examined adolescent fertility among secondary school girls. Analysis was made of :

1. Age at which adolescents engage in sex.
2. Measures adolescents take to ensure safe sex.
3. Pregnancy outcomes of unwanted pregnancy.
4. Health implications of adolescent pregnancy.
5. Safety chances of the abortions performed by adolescents.

The study findings are :-

1. A big percentage of girls engage in early sex.
2. Sex is unplanned, hence unsafe sex.
3. Large portion of unwanted pregnancies lead to abortion.
4. Abortions and early pregnancy lead to multiple health problems.
5. Most of the abortions are unsafe, and carried out by unqualified personnel.

This affects the general welfare of the adolescents and their future chances in life.

The last part of the study puts forth recommendations that are pertinent to policy-making. The main recommendation is that adolescent fertility should be regarded a serious problem and programmes and policies be designed to curb the factors contributing to the high adolescent fertility in Kenya.

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CHAPTER ONE

1.1 Introduction

Rapid population growth is a fundamental problem facing mankind today. The fact becomes even more significant in the context of socio-economic development. The risks of improvement in the quality of life involved in the problem arising out of growth of population are of such magnitude that even the slightest delay makes them more complicated and difficult to handle successfully.

About 50% of Kenyan Population is below 16 years of age (Kenya Demographic and Health Survey 1993). A young population requires a particular type of expenditure to support its schools, health facilities, transport, housing, food and job opportunities. These swelling numbers have resulted into rapid urbanization and the related environmental problems such as unemployment and social tensions among others. As a result crime, violence and other anti-social activities have increased considerably. These problems can only be successfully tackled in the context of the total population problem of the century. This could only be done if the plans of raising resources are complemented by measures of reducing population growth rate.

It is the youth's reproductive behaviour when they come of age which is going to affect considerably the population situation of the future. The need to catch them young is thus obvious and it is

here that Population Education becomes relevant as an important instrument of change, i.e. developing desirable attitudes that would lead to sound decision making by the individuals who are responsible to both individual and social good.

There is currently a heated debate on Population and Family Life Education and the morality of introducing it into the school curriculum. Simply defined, Population and Family Life Education (POPFILE) is a program of activities devised to assist learners to make informed and responsible decisions about issues which affect their welfare and that of their family, community and society. The program aims at developing responsible behavior achieved through their education so that the youth make responsible decisions on their own reproductive behavior.

The key concept here is responsible decision making which involves foreknowledge and understanding of the consequences of one's actions. This helps individuals regulate their lives and their environment. Population phenomena such as high fertility is related to quality of life, now and in the future. However, population is seen not only as a problem to be solved but also as a phenomenon to be understood. Relevance to the learners lies both now and in the future.

Studies have shown that many adolescents are sexually active and their lack of access to reproductive health information and services has resulted in high rates of adolescent pregnancy and sexually transmitted diseases including HIV and AIDS. Further studies have revealed that enabling the adolescent girl to make

decisions about child-bearing allows her to allocate time for education and economic activities. Unplanned pregnancies directly affect a girl's life chances. Research has indicated that adolescent fertility rates in Kenya are among the highest in Africa, (Geborah 1985A).

1.2 STATEMENT OF THE PROBLEM

There is a major nationwide concern about adolescent pregnancy and childbirth. Much of this concern has been centred on the impact of adolescent fertility on the overall population growth and school dropout. According to KDHS report of 1993, there is a direct contribution of early childbirth to Kenya's population whose age profile is skewed in the direction of those under twenty years. About a quarter of Kenya's population is aged 10-19 years, (Kenya Population Census 1989).

Pre-marital pregnancy is not a new phenomenon in Kenya. However, its association with moral, economic, health, social and psychological costs may be new. A girl who becomes pregnant is usually expelled from school. School dropouts lack skills and are vulnerable to exploitation in the labour market. Along with their children they risk malnutrition and disease. Their poverty is also passed on to their offsprings. Adolescent childbirth is therefore a major source of waste of human potential.

About 10,000 girls drop-out of primary and secondary schools annually because of unwanted pregnancy (Njau and Rogo, 1995). According to Division of Family Health/GTZ study in 1988, nearly 80% of girls who dropped out of school did so due to pregnancy as compared to other factors. Fifty percent wanted to go back to school after delivery, but were unable due to lack of fees and someone to care for their baby.

Early sexual activity predisposes teenagers to contraction of sexually transmitted diseases, cancer of the cervix and Acquired Immune Deficiency Syndrome (AIDS). Each year out of every 20 teenagers, one contracts a sexually transmitted disease (STD). Some STD's can cause life long disabilities, such as infertility, or even death. About half of all HIV infections so far have occurred in young people less than 25 years. Since the start of the pandemic, at least six million youth have been infected with HIV (Population Research Bureau, CPO and ICAF the World's Youth 1994. A special focus on Reproductive Health, 1994).

Teenage pregnancy and childbearing is also associated with many ante-natal and post-natal problems such as anaemia, hypertension, premature labour, infant mortality and maternal mortality. Given the stigmatization associated with pre-marital pregnancies and childbearing, many girls resort to either early marriage or abortion. Because abortion is illegal in many African countries, teenagers turn to conventional abortion methods associated with many health risks.

1.3 Justification of the Study

Early sexual experiences contribute to the major negative consequences of sexual intercourse that have become a source of concern for societies worldwide. Kenya, like many other African countries is no exception to this.

The adolescents' views on sexuality so far gathered appear to be ambivalent and at variance with their practices. For instance, nearly 80% of high school girls in Nairobi City felt it was wrong for school girls to have sexual intercourse. Sixty percent of active girls reported they did not want to have sex when it occurred, while fifty four percent reported to have enjoyed their initial coitus. In the rural studies, most girls felt that sexual intercourse was all right as long as pregnancy did not occur. The girls further felt that sex was not enjoyable when planned for (Mapara N. 1992). Since protection presupposed foreknowledge, the inference here is that adolescents predominantly practise unprotected coitus exposing themselves to pregnancy and STDs. Even when pregnancy is not the major issue with early onset of coitus in adolescent females, STDs pose other major gynaecological risks. Increasing medical practitioners at Kenyatta National Hospital are seeing cases of cytological changes in the cervix in patients below 20 years suggestive of increasing predisposition to cancer of the cervix at an early age. Therefore, a study attempting to harmonise all these conflicting findings is invaluable in planning future strategies. It is in this context that this study has been formulated.

A comprehensive curriculum on sex education does not exist in Kenyan schools syllabi. What scope there is for teaching sex education is limited to the physiology of human reproduction. Even then in a rural community, Maggwa in 1987 found that his study subjects had very low level of knowledge on reproductive biology. Lema (1987) also confirmed this. His study indicated that 71% of his female subjects did not know the safe days in the menstrual cycle (Barker, 1993).

It is the paucity in understanding adolescent culture that has rendered this task essential. One gets the impression that both parents and teachers lack the relevant tact and ingenuity in handling adolescent sexuality in part because they do not understand adolescent culture. Without a better understanding of the latter, their current socio-sexual scenario cannot be positively modified. So little information is imparted from parents and teachers that adolescents have to fend for themselves from equally uninformed sources. Teachers have done more than parents, the latter resigning themselves under the guise that teachers constitute the source of all knowledge.

This study hopes to pave the way for comprehensive programs that would contribute to an improvement of adolescent health and better fertility management, especially for the Kenyan school going adolescents.

1.4 Study Objectives

General objectives

The overall objective of this study is to investigate the social, demographic and health consequences of adolescent fertility.

Specific Objectives:

1. To find out the age at which adolescents engage in sexual activity.
2. To find out what measures adolescents adopt to avoid unwanted pregnancy.
3. To find out the outcomes of unwanted pregnancy among adolescents.
4. To find out the health implications of adolescent pregnancy.
5. To find out the safety chances of the abortions performed by adolescents.

1.5 Sources of Data and Background to the study Districts

This study is based on a nationwide survey on female adolescent health and sexuality in Kenyan Secondary Schools by AMREF's Family Health Unit in 1992.

The study was based on 9997 Kenyan Secondary School female adolescent in forms I-IV in September 1992.

The main ethnic groups, that is, groups with a population of more than 100,000 and representing over 93% of Kenya's population were selected using the Kenya Population Census data, 1979, Vol. 1 & 2, of the Central Bureau of Statistics. On the basis of these ethnic groups, 17 districts were chosen as survey districts with each district generally representing a different tribe.

A representative number of students were recruited from schools in each district using standard cluster sampling procedures.

1.6 Background Information

The study area covers a cross-section of Kenyan districts stretching from the Coast in the East to lake Victoria in the West. The districts represent the main ethnic groups in Kenya each with its own unique fertility related behaviour. Along the Coast there is Taita and Kilifi Districts that are generally characterised with early marriages. Towards the Central part of Kenya i.e. parts of Eastern and Central Kenya the dominant ethnic groups Kikuyu, Akamba, Meru and Embu are known for relatively high level of contraceptive use and lower levels of school drop out. In the Rift Valley and Western part of Kenya, the Kalenjin, Luhya and Kisii Communities are known for their low levels of contraceptive use, high school drop-out rates for girls and early age at marriage. The Lake region is dominated by the Luo Community who are widely known for continued attachment to their traditional beliefs that are generally pro-natalist. Polygamy is still widely practiced and therefore the adolescents who get children out of wedlock are sure

of getting married as second or third wives. Their levels of contraceptive use are one of the lowest in Kenya. They also have very high levels of school dropout for girls.

Data analysis

The study has utilised descriptive statistics. Cross tabulation was the main statistical measure used to show the relationship between the variables. Frequency distribution tables and percentages were used for comparison of various distributions of phenomena. Bar graphs were used to give pictorial presentation of phenomena where necessary.

1.7 Scope and Limitation

The methodology of analysis employed in the study; i.e. percentage distribution, cannot tell the significance of the of the variables on adolescent fertility. Therefore, the results obtained need to be tested by regression analysis which is beyond the scope of this study.

The data was obtained from a survey and may not reflect the true picture of the general population. Lastly the time allocated for the study is not adequate in carrying out a detailed study.

The data used had not been collected purposely for my study. Hence information that I would have wanted to use for the study may not be available e.g. school dropout, prevalence of sexually transmitted diseases and actual early marriages among others. Also only the information regarding the girls in school was available hence limiting the sample size.

As is the case with most other studies which use secondary data misreporting is a major problem. This can be detected in the analysis of the data.

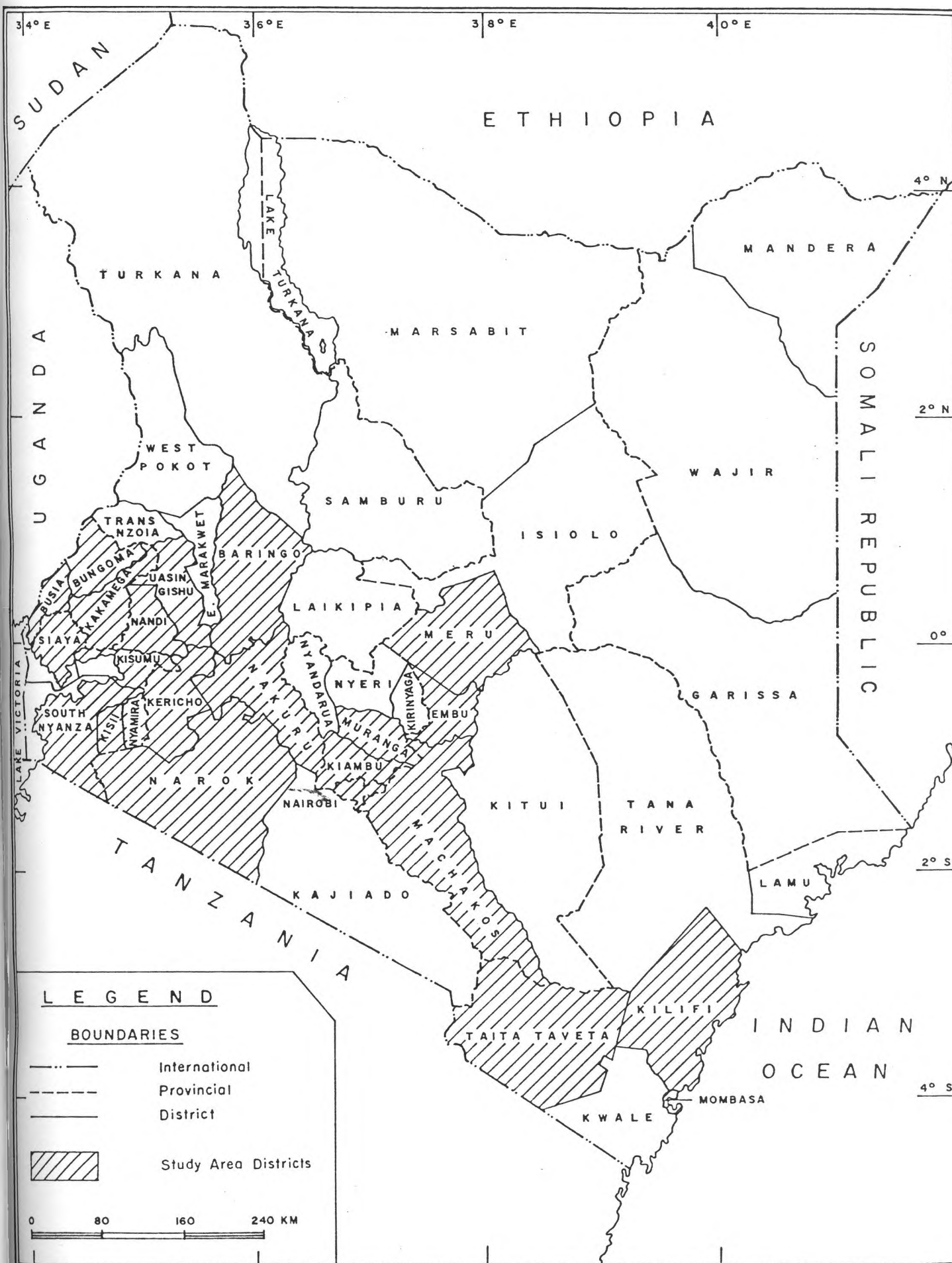


Fig. 1: STUDY DISTRICTS.

1.8 LITERATURE REVIEW

There is a major worldwide concern about adolescent pregnancy and childbirth. Much of this concern has been centred on overall population growth and school drop-out. There is also the direct contribution of early childbirth to Africa's population increase, which is all the more significant in national population whose age profiles are so skewed in the direction of those under 20 years. It is also of particular concern that in Africa, pregnancy normally terminates a girl's school career. Studies in several African countries have observed the strong association between early pregnancy and the significant levels of school drop-out rates. The retention rate for girls is lower than that for boys. Pregnancy is however, one among a range of factors which prevent girls in Africa from enrolling or once enrolled from continuing with schooling.

The consequences of early sexual debuts are a source of concern for societies worldwide due to their adverse effects on the individual female adolescent and society at large (Ahawo, 1981).

For the school-going female adolescent, early and unintended pregnancy is a major cause for discontinuation of education. Consequently opportunities that would have otherwise been available are foreclosed for the female due to unintended pregnancy during schooling years. She suffers from high risk of being too young at first delivery, high risk of infant death due to early pregnancy, poor economic status and negative social reaction to the teenage pregnancy.

Teenage pregnancies are considered obstetrically 'at risk' worldwide due to inadequate pelvic formation and inadequate psychological maturity and preparedness among pregnant adolescents (Ajayi, Marangu and Paxman 1989).

The statistics that follow reflect the gravity of the problems associated with teenage pregnancy globally. About 11% of an estimated 123 million women who give birth worldwide each year have not reached adulthood (Baker of Neidells, 1990). On the other hand, five hundred thousand women die every year worldwide as a result of pregnancy. Although there is no breakdown of the age mortality rates for adolescents, if rough estimates were to be computed using mean adolescent fertility rates worldwide high mortality rates would be noted among the age group.

The 1975 age specific fertility rate for United States women aged 15-19 years was 58/1000 women (Division of Family life Health, 1988). According to the Allan Guttmacher Institute, if the current trends in adolescent fertility continue, nearly 40% of today's 14 year old girls in the United States, will become pregnant before their twentieth birthday. In Great Britain, 1 in 5 girls get pregnant by the age of twenty years . These are high figures for developed countries with well developed population programs (Centre for Population Options, 1992).

Unfortunately, the status of adolescent fertility in the developing countries is neither as well documented nor as easily summarized. There are very few sources of data and the countries differ greatly in geography, cultural background, religion,

economics and fertility attitudes and practices. As a result, the limited population statistics available are mostly incomplete and in some instances inconsistent. There are also other elements of variation including rural-urban migration that further compound the problem of access to fertility information.

Nevertheless, available data reveal high adolescent fertility rates for developing countries.

In 1974, age specific fertility rates for 15-19 year old women was about 120/1000 in Indonesia, 198/1000 in Bangladesh and 160/1000 in Jamaica . Although there are no recent data on the trends, the above data show high fertility in the Asian Sub-continent and the Carribean when compared to the U.S. and Great Britain.

In Africa, adolescent fertility rates are also high. In Liberia, the age specific fertility was reported as 230/1000 women (Gardner H. 1993). The most recent data on Liberia (1985) ranked its adolescent fertility rate 6th amongst 25 African Nations. Nigeria's adolescent fertility rate which is lower than the rest of the African countries for the same age group (127/1000), in 1985, is still considered high because adolescents contribute 11% of Nigeria's Total Fertility Rate (TFR) (Couclough and Lewin, 1993).

Uganda's adolescent fertility rate for the age group 15-19 years from the only available data (1969) was 172/1000 women, while Tanzania's for the same group based on 1972-79 figures was slightly lower at 137/1000 women (Ferguson, 1988).

Kenya's fertility rate for adolescents aged 15-19 years is 150/1000 women (1989) (Morgan et al, 1987). These high adolescent fertility rates in Africa are a cause of concern because they contribute significant percentage to the total fertility rate of these countries.

At the same time, population growth rates have continued to rise for developing countries. In Africa today, the population doubles every 20 years. From 430 million during the mid-eighties, the continent will have to sustain approximately 900 million people by the turn of the century (Gardner H. 1953).

Besides high adolescent fertility rates and rising population, the pregnancy associated risks and deaths for women in general and adolescents in particular are considerable.

Of 500,000 women who die every year worldwide as a result of pregnancy, 40% die due to abortions done under inadequate conditions. Almost all of these women live in developing countries (Baker, 1990). Since, in Africa, the most neglected target group of all are the adolescents, who make up half of Africa's population, it is conceivable that considerable numbers of those deaths are of adolescents. Their sexuality is tabooed by parents as well as governments. Yet because of their ignorance and increased sexual activity they are more exposed to unwanted pregnancies, illegal abortions and STDS including AIDS (Baker, 1990).

In Liberia, a study in Monrovia showed that over 50% of the students and 33% of the non-students aged 12-19 years who became

pregnant outside marriage resorted to induced abortion (Centre for Population Options, 1992). In Sierra Leone, adolescents aged 15-19 and 20-24 accounted for 23% and 21% respectively, of all abortions in 1980. Further 80% of all the patients with induced abortion were aged 15-25 and 30% of them had experienced previous abortion (Garbrah B. 1992). In Nigeria, of all adolescents who become pregnant, 90% choose abortion (Lewin, 1993). In Kenya, induced illegal abortions account for 84% of all septic abortions (Ajayi et al, 1981). Indeed abortion in Africa constitutes 20% of maternal mortalities.

Thirdly , due to the government policy on abortion and the resultant lack of poor antenatal care, adolescents seek the services of unskilled abortionists.

In Africa, young age at marriage or first delivery, low educational level, low economic status and repeated deliveries are the four major factors associated with poor obstetric outcomes. The risks of not surviving a pregnancy is 300 times greater in Africa than for women in the industrialised countries (Baker, 1990).

And although the detrimental effects of early childbirth on the mother and child are well-known they are not satisfactorily documented in Africa.

In view of the fact that developing countries have low Contraceptive Prevalence Rate (CPR) and that adolescent coitus may result in unwanted pregnancy, illegal abortion, sexually transmitted disease including the fatal disease, AIDs , there is

an urgent need to focus on female adolescent sexual behaviour.

In Kenya, both adolescent contraception and termination of pregnancy are illegal. Adolescent pregnancy occurs in the context of profound social disapproval, interruption of schooling, loss of future income and uncertainty of parental care. This is because it precedes completion of education, securing of employment and the creation of a stable relationship within or without the legal bond of marriage. Consequently the pregnant adolescent has two grim choices: childbirth or illegal abortion. The former option is rife with obstetric risk associated with young maternal age (Ladipo, 1992).

According to a study carried out by the Division of Family Health/GTZ, 1988 an estimated 10-12% of girls drop-out of primary and secondary school, while 6-7% drop-out of Teacher Training Colleges every year due to pregnancy, While data on the direct contribution of pregnancy to school drop-out visa vis other factors is scarce, available data in Kenya indicate that it is significant. According to the Division of Family Health/GTZ 1988 study nearly 80% of girls who dropped out of school did so mainly due to pregnancy as compared to other factors. Pregnancy disrupts a girl's education in many other ways: absenteeism, poor performance stress and eventual school drop-out (Njau and Wamahiu, 1994).

Adolescent pregnancy and(or) childbirth is a major source of waste of human potential and social injustice.

Njogu(1980) conducted a study among school girls in Naivasha

who dropped out of school due to pregnancy. They had psychological problems and were unable to feed and clothe their babies adequately.

Mangoka (1984) found out that dropping out of school prematurely limits career development and entry into gainful employment thus leading to perpetual poverty.

John Townsend, (1985) conducted a survey in two urban areas of Mexico City on sex education. He focused on both males and females aged 15-25 years. Nearly 85% of his respondents were aware of unintended pregnancies among their peers and 75% felt that they lacked information about sex and reproduction but they didn't know where to go for reliable information.

Data relating to the behaviour of Kenyan adolescents clearly indicate that many young people are NOT making responsible decisions about population and family life issues which have immediate and serious repercussions upon their health and welfare.

A number of researches dealing with early adolescent reproductive health in the 1990's point to a number of important findings. In their study on early adolescent reproductive health, Njau and Rogo (1995) have shown that in Kenya sexual relations begin early in the life cycle, and that by the age of sixteen a majority of young people are sexually active. They have further shown that in Kenya those relationships largely but not solely with agemates, are on some 30 percent of cases characterized by involvement with multiple partners. They also found that the vast majority (80 percent or more) of such relationships involve sexual

intercourse which is both unplanned and unprotected and that in Kenya a third of sexually active girls claim that initial experience was the consequence of trickery or coercion. They have indicated that as a consequence of the above behaviour, unplanned pregnancy will be an experience of one girl in every ten presently enrolled in upper primary or secondary schools and some 10,000 to 13,000 girls drop out of school annually due to unintended pregnancy.

National Survey on youth reproductive health and sexuality and their related problems have shown that adolescent Fertility rates in Kenya are high. The demographic significance of the youth in Kenya derives from its current and potential contribution to fertility. According to KDHS 1993 findings, the estimated fertility or birth rate for 15-19 year olds is 110 births per 1000 which translates into 142,000 births per year or 11.4 per cent of all births. The average age at menarche has fallen to 13 years. It is further reported that childbearing begins early in Kenya (KDHS, 1993). One in five teenage women (15-19) had began childbearing (either given birth or is pregnant with her first child). By the time they reach 19 years, 40 percent of women have began child bearing. The survey further indicated that 17 percent of all 15-19 years old women have at least 1 child and another 8.6 percent were pregnant at the time of the survey. In spite of the general fertility decline throughout Kenya, the rate for the adolescent group was much slower than for the older age groups.

In a study done by Njau in 1993, 81 per cent of girls (age 15-19) interviewed in 4 rural districts had at least one pregnancy, 14 per cent 2, 3.2 percent 3, 0.7 percent 4 and 0.1 percent 5, 10 percent became mothers before the age of 16 while the remaining 89 percent waited until 18 years. The study further showed that - 24 percent of the girls were pregnant at the time of the survey, 57 had delivered once and 4 percent had had more than two pregnancies. Other studies have shown that by the age of 20, about 21 percent of Kenyan adolescents have had at least one child.

At another level, it has been shown that sexual activity among adolescents in Kenya is high and is associated with biological, social and economic factors such as early puberty, economic hardships, urbanization, schooling and weakening of traditional structures that regulated young people's sexual behaviour. It is further pointed out that high teenage sexual activity is reflected in the high incidences of pregnancy, abortion and STDs. It is therefore suggested that adolescents must be provided with education and skills that will enable them to postpone their initiation of sexual activity. The above observations are based on the fact that about 4 percent teenagers initiate coitus before age 10 according to a 1993 study of Nyeri District which also showed a mean sexual initiation of 13.5 years for both boys and girls. Comparison of data from the 1989 and 1993 KDHS shows a slight increase in the median age at first intercourse. About 26 percent of single women aged 15-19 have had sexual intercourse.

A study carried out on Female Adolescent Sexuality in Kenyan Secondary Schools revealed that first coitus among girls below the age of 15 years was highest among the Embu and Meru (44-50%) and lowest among the Taita and Luhya (30%). About 83 percent of teenagers in the study had initiated coitus by 19 years, while 34 per cent had had at least one sexual experience. Between 26-46 percent of unmarried teenagers aged 15-19 were sexually active.

Premarital pregnancies are explained by an interplay of individual and social factors within the context of the communities in which the teenagers live. The extent to which the community intervenes in the regulation and management of sexual behaviour of the general population and teenagers in particular is found to be a crucial factor in determining whether or not pregnancies occur. Teenage pregnancy is associated with the grave social, economic, demographic and other health consequences. Early sexual activity in the absence of knowledge and contraceptive use is a major contributor to teenage pregnancy (Rogo and Njau, 1995). Their study has revealed that the rate of teenage pregnancy in Kenya is high and girls as young as 11 years old are getting pregnant. Over 40 percent of women aged 19 years have begun childbearing.

A study conducted at the Pumwani Maternity Hospital between February and March 1986 revealed that births to adolescents accounted for 28.9 percent of the total deliveries at the hospital.

Demographically, teenage pregnancies contribute significantly to the already high population growth in Kenya whereby teenagers account for between 20 -30 per cent of the total pregnancies

occurring among women aged 15-49 years. The Kenya contraceptive prevalence survey (KCPS 1989) showed that whereas the prevalence of pregnancy decreased by between 1 and 3 percent in age group 20-49, it remained the same for the age group 15-19. According to Kenya Demographic Health Survey Data, of those adolescents aged 15-19 who get pregnant, 28 percent do so after marriage, 32 percent before marriage, while the remaining 40 percent never get married. A study in Kiambu found that about 55 percent of the adolescent girls aged 15-19 had had a pre-marital pregnancy and 55% of the adolescent boys had made a girl pregnant.

A review of adolescent pregnancy at Kenyatta National Hospital (by GTZ, 1988) found that 11% of the total deliveries were to adolescents 19 years old or below. Of these, 25% were below 16 years. In the same hospital, "the youngest recorded delivery was by a mother of 10 years and 3 months old at term". She must have conceived at age 9 ½ years and most likely engaged in sexual intercourse even earlier (Ladipo, 1992).

The first problem related to adolescent pregnancy is that those who opt to carry their pregnancies to term do not seek antenatal care. This leads to an increased risk and rate of antenatal and perinatal complications. At K.N.H., Ngoka (1988) year found that preterm delivery and low birth-weight babies occurred more frequently among adolescents. The pregnancies are associated with high perinatal mortality and premature rupture of the membranes, anaemia, antepartum haemorrhage hypertension and STDs (Ajayi 1989).

Termination of pregnancy poses a different set of potential dangers: first termination is a criminal offence - by both the abortionist and the person seeking abortion - punishable under the law. Secondly, since the procedure is carried out by unskilled clandestine backstreet abortionists, sepsis rates are high. So are the rates of haemorrhage. These result in high maternal and infant morbidity and mortality rates. One of the earliest complications of adolescent pregnancy is abortion. Abortion is the commonest diagnosis among gynaecological in-patients at K.N.H. A study at K.N.H. found that 84% of all septic abortions were to adolescents aged 14-20 years old (Ajayi, 1989).

Besides pregnancy, sexually active adolescents suffer a disproportionate increase in STD rates compared to adults. The younger the adolescent, the higher the rates. In a study of 500 antenatal subjects in Nairobi in 1989, Okumu found significantly high STD infection rates among teenaged women 15-19 years old who comprised 18% of the sample size. The highest infection rates for gonorrhoea (10%), trachomatis (10%), vaginalis (28%) and syphilis (5%) were found among teenagers between 15-19 years old.

Besides the individual, adolescent pregnancies affect adversely the economies of many developing nations. The population of Kenya is 24.5 million. Of these, 50% are children under 15 years of age. A significant proportion of these are adolescents. Yet the adolescent culture has only recently emerged as a distinct entity, having been buried for generations within the cultural provision of early marriage and childbearing.

Studies on adolescence in Kenya have examined their social-demographic characteristic, sexuality in general and fertility in particular. Cross-sectional surveys of small samples and mainly schools and other institutions of higher learning have provided the most information. From available data, the adolescent population in Kenya was 3.9 million in 1985. This number today constitutes a 100% increase from 1.8 million in 1969. The fraction of educated adolescents has also increased. In 1985, of all adolescents aged 15-19 years 15%, 49% and 19% had obtained 1-4, 5-8 and 9+ years of education respectively. The remaining 17%, however, had no education at all. Of women aged 20-24 years at the time, 30% had no education at all, 17% had 1-4 years and 34% had 5-8 years of education 19% had 9+ years of formal education.

A study in 1985 in Kenya depicted an adolescent population that professed a Christian religion, tended to live in urban centres, has low labour force participation rates, tended to marry at later ages and have less stable marriages than those of older generations. The same study in 1985 and another in 1989 also showed that the adolescent community in Kenya has a higher fertility rate and contributes significantly to Kenya's population growth. The fertility rate among teenagers aged 15-19 years rose from 141 live births per 1000 women in 1962 to 168/1000 women in 1979, despite a decline in the proportion of married teenagers

The age-specific fertility rate for women aged 20-24 years rose from 304/1000 women in 1962 to 342/1000 women in 1978. Kenya's overall adolescent fertility level is among the highest in

Africa. A study in (1989) shows an adolescent fertility rate of 150/1000 women . Adolescent fertility pattern in Kenya has remained high over the last 20 years. In 1962, the adolescent fertility rate stood at 141/1000 women. This rose to 168/1000 in 1997, despite considerable efforts to address the problem of high school girl pregnancy and drop out rates. In 1989, the rate had fallen slightly to 150/1000 . This trend is encouraging but not a cause for complacency, especially given the fact that contribution to total fertility by adolescents has risen from 11% in 1977 to nearly 20% in 1989. The small decline 1989 is a deterioration of the adolescent's lot following initiation of that fertility rates is an inadequate measure of sexual behaviour because it only reflects pregnancies that result in life births in a given year.

The incidence of teenage pregnancy was reported in a 1986 study to be 10% . In Nairobi, 20-30% of all deliveries in maternity institutions were to teenage mothers. In 1986, 28% of mothers delivering at Pumwani Maternity Hospital (PMH) were under 16 years of age and their average parity was 1.03. Among adolescents aged 17-20, the average parity was 1.35 (Ajayi, 1989). Given that the hospital handles over 20,000 deliveries a year, the above statistics represent a worrying proportion of teenage motherhood. A mean parity of greater than one at age 16 or below indicates an early onset of coital activity. A 16 year old girl delivering a second child must have conceived a year earlier at age 15. Even if she conceived only six months after the birth of the

first child that would put conception of the first pregnancy 15 months away-less than 14 years. While many girls will conceive at their first attempt at coitus, it is for some time indicating that her sexual debut was at a much younger age (Ladipo, 1992). Coupled with high teenage abortion rates at the Kenyatta National Hospital and other hospitals, the issue of adolescent sexuality needs to be urgently addressed. To do so, we need to know what the adolescents' own perception of their situation is and the factors influencing their situation. This study is intended to obtain some information in this area. High school girls comprise a small proportion of all adolescents in Kenya. Still, they are a vital fraction and the information gathered will be immensely useful in the designing of intervention programs.

Most researchers agree that Kenya's high adolescent fertility is related to high levels of sexual activity among adolescents accompanied by low contraceptive use (Mapara H. 1992). In 1974 a small survey of some Kenyan High Schools and Colleges showed that 46% of them were sexually active. It is noteworthy that college girls in Kenya are not subject to the same socio-sexual constraints as high school girls. For instance, at the national universities, pregnant students continue with their studies, while high school girls are discontinued on becoming pregnant. Statistics between these two categories of students give a clearer picture of the magnitude of the risk of pregnancy in relation to continuation of studies.

In 1987, a survey of high school girls in Nairobi City and a rural area showed that 24% of the urban and 58% of the rural girls were sexually active (Mapara, 1992). There is disparity in sexual activity between urban and rural school girls. It has been hypothesised that urban school girls, exposed as they are to mass media, a cosmopolitan population and a more sexually stimulating environment, are likely to be more sexually active.

To illustrate the mean age at first coitus for high school girls in Nairobi was 14 years. Four percent of those surveyed, however, had their initial coitus before their 10th birthday. Most of these girls had engaged in coitus with mature men. In contrast, a study in a rural set up within 40 kms of Nairobi showed that girls engage in sex with boys of the same age (Mapara N. 1992). It is therefore important to establish a national perspective on the age at which female adolescents start engaging in coitus and who the sex partners for the female adolescents are, in order to target intervention accordingly. This can be illustrated by a National study of Kenya schools which found that 7 percent of the sexually active girls had previously been pregnant at least once and 11 percent were pregnant at the time of the survey.

Data suggest that premarital pregnancy is not a new phenomenon in Kenya. What might be new is its association with economic, social and psychological costs, since a girl who becomes pregnant is usually expelled from school. Few support networks exist to enable her to continue, as a result of the stigma associated with

her condition. School drop-out is one of the major consequences of pregnancy in Kenya.

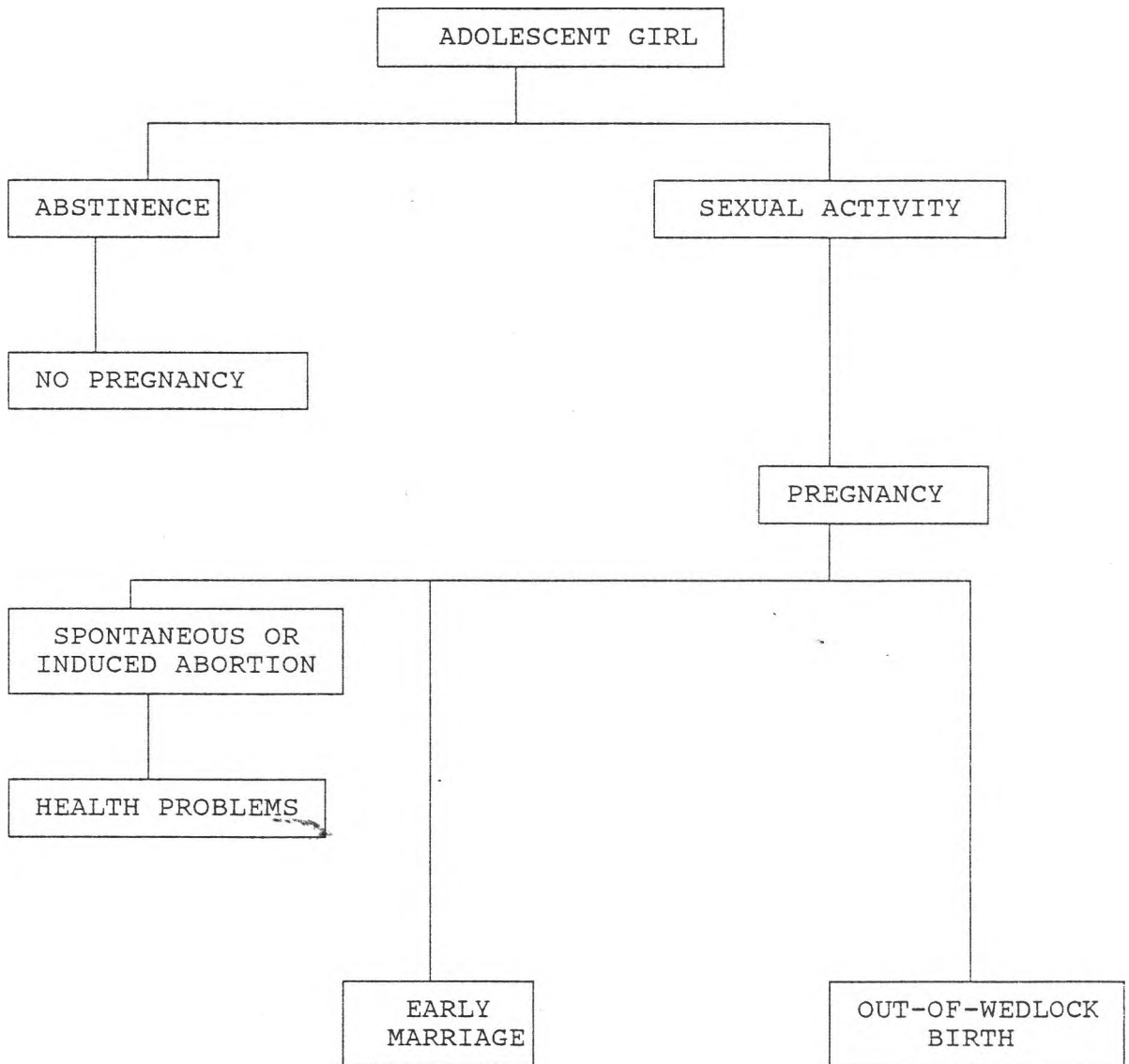
It is worth noting that the majority of girls who drop out due to pregnancy do not resume their studies. Out of those who do, very few return to their previous schools. Most go to relatively poor schools. A study of 1058 adolescents showed that 42 percent of adolescents interviewed in a study of 1058 adolescents first got pregnant while in school. All of them had to quit school as a consequence of the pregnancy. Among them, 50 percent wanted to go back to school after delivery, but were unable due to lack of fees and someone to care for their baby.

According to a report from UNFPA on the state of World Population, 1995, enabling women to make decisions about childbearing allows them to allocate time for education and economic and political activities. Unplanned pregnancies directly affect women's life chances. Thus, a need to provide adolescents with information and services to combat unwanted pregnancy is paramount.

1.9 THEORETICAL FRAMEWORK

Based on the foregoing literature review the following theoretical framework will be used for this study. The framework considers the complex factors related to adolescent sexuality as explained above although it does not completely cover all the factors involved.

THEORETICAL FRAMEWORK



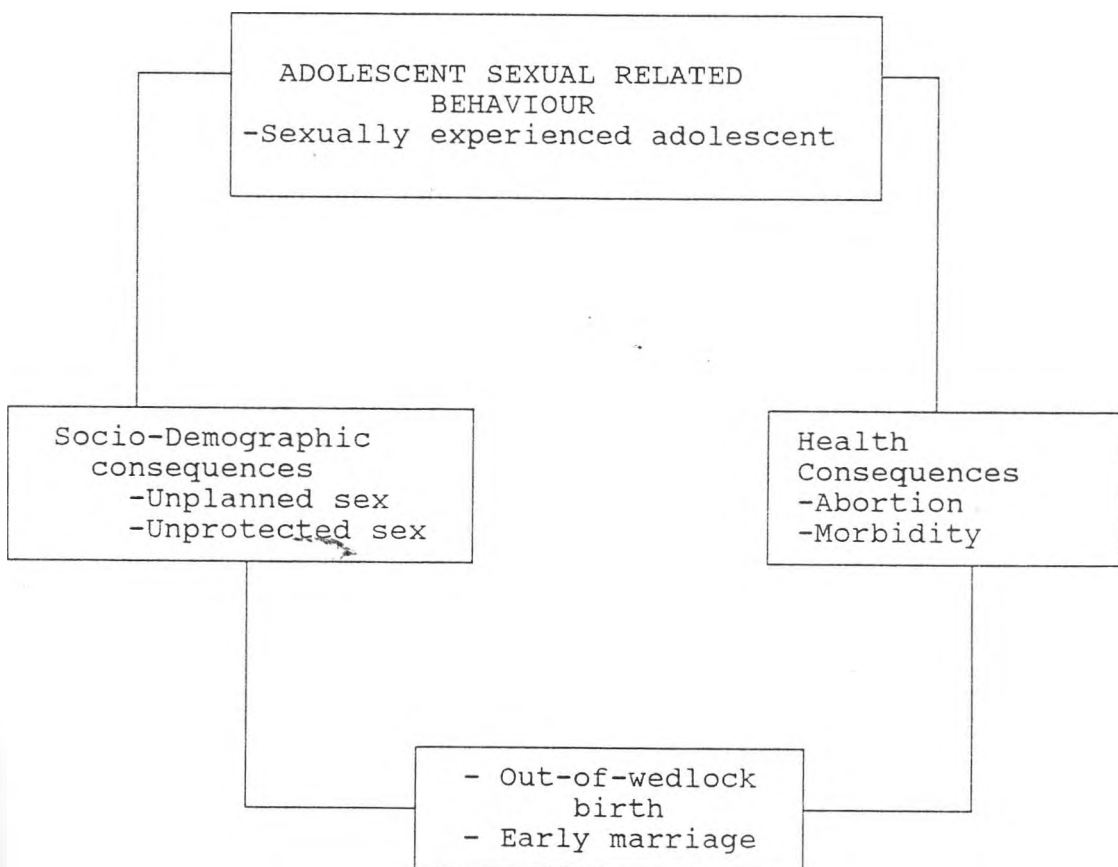
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1.10

OPERATIONAL FRAMEWORK

In order to examine some of the consequences of adolescent sexuality the following analytical framework will be used on this study. The framework considers the adolescent sex behaviour and their consequences.

Operational Model



1.11 Hypothesis

The following hypothesis will be tested for this study.

1. Age at first sexual intercourse among female adolescents is below 15 years for at least 17% of female adolescents.
2. The rate of unprotected sexual intercourse among female adolescents is higher than 80%.
3. Majority of abortions performed by adolescent are back - street abortions.
4. Majority of adolescent are ignorant about the measures to take in order to avoid unwanted pregnancy.
5. Majority of the sexually active adolescents have never used any contraceptive.

CHAPTER TWO

Data Analysis and Findings

The study came up with a number of findings as indicated below. Some of the findings conform with earlier findings by other researchers.

Table I shows that the Luo Community has the highest percentage of sexually experienced girls (50.9%). The Community also has the highest percentage of girls with multiple sex partners (46.6%). The percentage of ever-pregnant girls is relatively low (7.5%). This low percentage can be attributed to relatively high level of knowledge of safe days (30.6%) and percentage of girls who ever-used contraceptives (19.7%). The Community is also known for their strong belief in traditional sex taboos. For instance during the mourning periods abstinence is practiced. Majority of the girls also drop out of school early and therefore were not interviewed.

The low percentage of ever-pregnant girls can also be attributed to the practice of multiple sex partners which is related to the prevalence of the traditional practice of polygamy. The high percentage of sexually experienced girls can also be related to breakdown of traditional moral values such as virginity.

Table 1: SEXUALLY RELATED BEHAVIOURS AMONG GIRLS FROM VARIOUS ETHNIC COMMUNITY

Ethnic Group	Ever-Used Contraceptives n=2931	Sexually Experienced Girls n=9214	Ever Pregnant Girls n=3011	Girls with multiple sexual partners among sexually experienced girls n=2921	Sexually experienced girls by age 15. n=2860	Knowledge of safe days n=9294
<u>Luo</u>	19.7% (700)	50.9% (734)	7.5 (729)	46.6% (708)	34.2% (709)	30.6% (143)
<u>Kikuyu</u>	16.8% (702)	37.9% (718)	6.7% (713)	36.1% (680)	36.1% (556)	31.7% (1914)
<u>Luhya</u>	17.3 (271)	27.9% (284)	5.1% (272)	35% (274)	30.3% (269)	22.9% (3034)
<u>Kamba</u>	15.3 (222)	29.9% (238)	2.2% (232)	33.8% (219)	32.9% (207)	27.6% (825)
<u>Kalenjin</u>	7.9% (340)	28.4% (364)	10.7% (346)	29% (348)	37.7% (340)	30.5% (1291)
<u>Meru</u>	24.7% (198)	-	5.4% (205)	32.5% (188)	43.6% (185)	33.5% (537)
<u>Embu</u>	16.7% (126)	-	3.1% (129)	33.6% (125)	49.6% (125)	28.1% (509)
<u>Taita</u>	28.2% (110)	27.2% (121)	4.3% 115	32.8% (116)	34.6% (113)	23.7% (439)
<u>Kisii</u>	21.4% (262)	40.3% (274)	10.4% (270)	33.5% (263)	38% (254)	26.5% (684)

before marriage.

The Kikuyu community had the second highest percentage of girls with multiple sex partners (36.7%) and the percentage of girls with knowledge of safe days (31.7%). The community had third position in percentage of girls who were sexually experienced (37.9%) and fourth position among ever-pregnant girls (6.7%). The percentage of girls who ever-used contraceptives was quite low (16.8%).

The high percentage of girls with multiple sex partners can be explained by breakdown of traditional moral values and prostitution, as a means of earning a living. The relatively high percentage of girls exposed to sex may be due to declining value attached to chastity and virginity before marriage.

Contraceptive use was quite low among the school girls, hence relatively high percentage of ever-pregnant girls. However, this percentage is lowered by their high percentage of knowledge of safe days (31.7%). Among the Kikuyu community school drop-out by girls is low. Even those who give birth normally go back to school and this may explain the higher percentage of ever-pregnant girls.

The Kamba girls had the lowest percentage of ever-pregnant girls (2.2%) and girls exposed to sex by age 15 (32.9%). The percentage of girls exposed to sex is generally low (29.4%) and only 33.8% had multiple sex partners. Knowledge of safe days was relatively low (27.6%) and so was contraceptive use (15.3%).

The above scenerio among the Akamba community can be explained in many ways. For instance, sex education is traditionally encouraged. Irresponsible sex behaviour is highly discouraged.

Although sexual experiences is encouraged before marriage it is normally guided by elderly women in society, taking necessary precautions.

Among the Taita the percentage of girls exposed to sex was quite low (27.2%). However, most of these girls used contraceptives (28.2%) and hence the low percentage of ever-pregnant girls (4.3%).

This can be explained by the fact that the community is predominantly Muslim. Sex outside marriage is completely prohibited. Girls are also married off quite early and thus are referred to as adults hence were not respondents in the survey. This can be emphasized by the low number of respondents (about 115).

Islam also accomodates many aspects of African traditions and hence moral values such as virginity until marriage are highly upheld.

The Kalenjin had the highest percentage of ever pregnant girls (10.7%). The percentage of girls who ever-used contraceptives was the lowest (7.9%). This can be explained by the low levels of education in the community and low use of contraceptives.

Among the Kisii community the percentage of sexually experienced girls was quite high (40.3%). So was the percentage of ever-pregnant girls (10.4%). The girls get exposed to sex early (38% by age of 15). The level of knowledge of safe days was quite low (26.5%). This explains why Kisii district has one of the highest fertility levels and most densely populated in Kenya. This

can be explained by degeneration of traditional values.

The Embu community had the highest percentage of girls exposed to sex by the age of 15 (49.6% of sexually experienced girls). However, 28.1% of all Embu girls interviewed had knowledge of safe days and 16.7% had used contraceptive among sexually experienced girls. This may explain the low percentage of ever-pregnant girls (3.1%) in the community.

Among the Meru, 43.6% of girls exposed to sex were sexually experienced by age 15. They had the highest percentage of girls with knowledge of safe days (33.5% of all sexually experienced girls). Their percentage of ever-used contraceptives was second highest (25.7%). The two can explain the relatively low percentage of ever-pregnant girls (5.4%).

Sexually Related

Behaviour by age

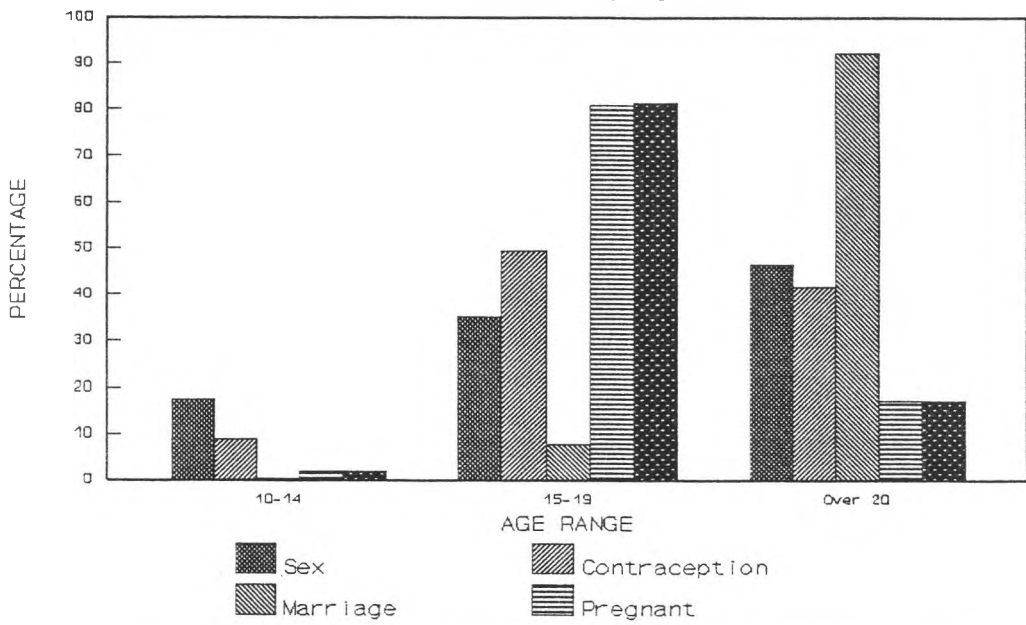


Fig 2.

Table 2: Sexually Related Behaviour by Age

AGE RANGE	Sex n=9868	Contracep tives n=7092	Marriage n=9375	Pregnant n=221	Abortion n=221
10-14	17.4% (1717)	8.9 (633)	0.2 (1687)	1.8 (4)	1.8% (4)
15-19	35.1% (3464)	49.5 (3,514)	7.7 (19)	81 (180)	81.4% (180)
20+	46.5% (4589)	41.6 (2,945)	92.1 (722)	17.2 (38)	17.2% (38)
TOTAL	100%	100%	100%	100%	100%

Table 2 shows that only a small percentage of girls (17.49) believed that coitus can start before age 15. Only 8.9% believed in the use of contraceptives before age 15 and 0.2% thought it was ideal time to start planning for marriage. This explains the low percentage of pregnant girls in the age range 10-14 (1.8%). These pregnancies are unintended and hence a high percentage of abortion (50%).

Girls within the age-range 15-19 had 36.1% of them believing that this was an ideal age for coitus. Almost half of them 49.5% believed that this was an ideal time to use contraceptives. However, only a mere 7.7% thought it was an ideal age to start planning for marriage. Nevertheless most pregnancies among girls were registered here (81%). There is also a high percentage of abortion as a pregnancy outcome (81.4%).

Majority felt that the ideal age to start planning for marriage is age 20+ (92.1). This age range also reflects a relatively lower percentage of abortion (17.2%).

Table 3: Sexually Related Behaviour By Residence

Place of Residence	Use of contraceptives	n=9603 Source of guidance on sexuality					n=196 Choice of Abortion Performance			Media Type				
		*P	R	T/C	H/P	O	Doctor	Other	Self	M/ Radio	TV	NP	Movie	Others
Urban	21.0 n=555	18.4	44.1	19	8.9	2.7	53.3	17.7	28.9	19.4	12.4	39.6	24.7	3.9
Rural	14.9 n=55	17.9	42.4	16.7	9.0	2.6	40.3	29.9	29.5	27.5	8.6	48.3	11.5	4.1

* P-Peer, R-Relatives, T/C-Teacher/Church, H/P-Health Professional, O-C

Table 3 shows that the urban girls had a higher percentage of use of contraceptives (21%) compared to only 14.9% among rural girls. This can be explained by the differentials in access to qualified medical doctors, the television and the movie/films between the urban and rural girls.

While 53.3% of urban girls consult doctors for abortion, only 40.3% of rural girls do so. Exposure to T.V. and movie/films was 12.4% and 24.7% respectively for urban girls compared to 8.6% and 11.5% for the rural girls respectively.

It is evident that matters related to contraceptive use can very effectively be communicated through the two media than say magazines given that Kenyans are said to be poor readers generally.

The table also shows that the rural girls who seek professional assistance to carry out an abortion are more accessible to junior medical officers (29.9%) compared to only 17.7% in urban areas. However, the table shows that backstreet abortions occur at more or less the same frequency in both rural and urban areas. This could be the case because most girls want to do abortion incognito.

Sources of information and guidance on sexual matters tended to be more or less uniform in both urban and rural schools. Majority of the girls turned to relatives, peers and the teachers for information. Not much use is made of the medical professionals. This may be due to the prevalence of use of unkind language to clients especially in public medical places by the nurses.

Table 4: Pregnancy experiences and health status among girls

Self-reported Health status	n=3235 % Ever-pregnant	
	Yes	No
Excellent	11.7	13.1
Good	39.6	48.2
Fair	43.7	36.4
Poor	5.0	2.3
Total	100.0	100.0

Table 4 shows that the ever-pregnant girls reported lower health status compared to those with no pregnancy experience. While only 11.7% of the ever-pregnant girls reported excellent health status, 13.1% reported the same among never-pregnant girls 39.6% and 48.2% respectively reported good health.

On the other hand the ever-pregnant girls had higher percentages of girls who reported fair (43.7%) and poor (5.0%) health status. The never pregnant girls reported 36.4% and 2.3% respectively.

While it is a fact that pregnancy is associated with health problems even among women who are of age, the risks related to the health of a mother decrease with age. Young mothers are normally ill-prepared for childbirth not only biologically, but also psychologically. The social, economic and psychological problems related to early pregnancy increase the chances of ill health among adolescent mothers.

Pregnancy experience and Health Status among girls

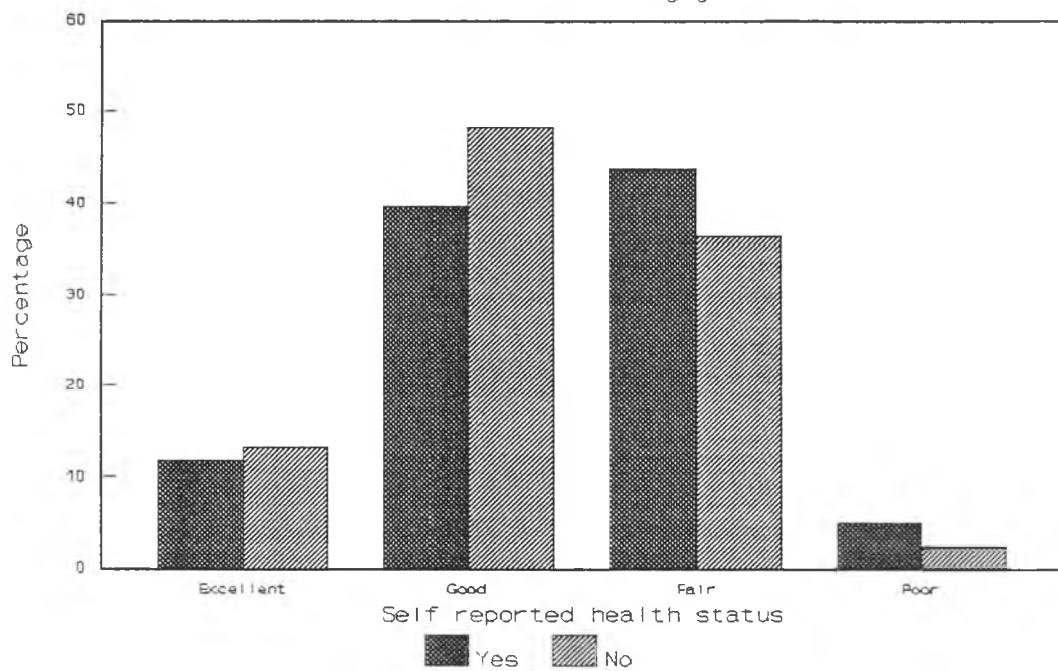


Fig 3.

Table 5: Pregnancy outcome and self reported health status among ever-pregnant school girls

n=234 Pregnancy outcome	% Self- reported health status			
	Excellent	Good	Fair	Poor
Abortion	44.4	41.1	43.6	45.5
Delivery	40.7	44.2	49.5	45.5
Still- pregnant	14.8	14.7	6.9	9.1
Total	99.9	100.0	100.0	100.0

Table 5 shows the differentials in health status in relation to pregnancy outcome. A high percentage (44.4%) of girls who carried out an abortion reported excellent health status while a lower percentage (40.7%) of girls who delivered had excellent health status. Among those who reported a fair status, 43.6% had aborted while 49.5% had delivered and 6.9% were still pregnant. For the category that reported poor health status both those who aborted and those who delivered scored 45.5% and only 9.1% were still pregnant.

The above findings show that among girls who become pregnant at an early age, pregnancy outcomes, abortion and delivery have more or less equal health risks. There is no significant difference between whether a girl aborted or delivered.

Pregnancy outcome and health status
among ever pregnant school girls.

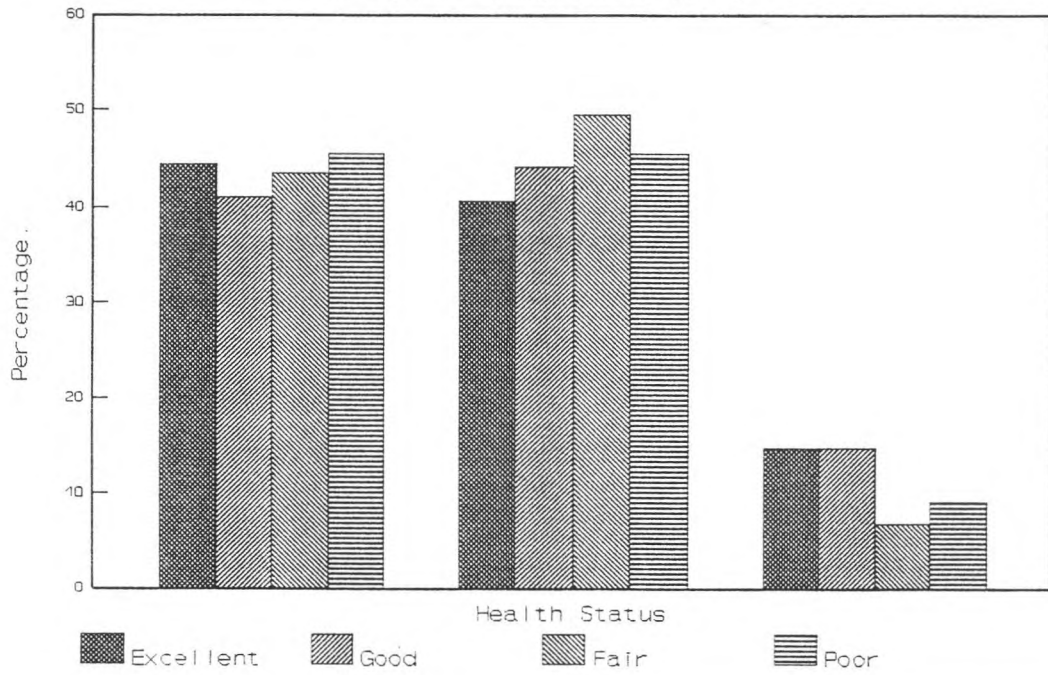


Fig 4.

CHAPTER THREE

Summary, Conclusions, Recommendations and Policy Implications

Summary and Conclusions:

The study has revealed that adolescents engage in sexual activity early in Kenya. Majority of the sexually active girls also engage in unprotected sex. The study has shown that levels of contraceptive use are low. This results in unwanted pregnancies that finally lead to abortion, out-of-wedlock births or early unplanned marriages. Adolescent pregnancy is also responsible for the numerous health problems among these adolescent resulting from either a birth at an early age or unsafe abortion. The overall objective of this study was to investigate the social, demographic and health consequences of adolescent sexuality and fertility. The study has shown that adolescents in Kenya are getting exposed to sexual activity before they get to age 15. The study also aimed at finding out the safety measures the adolescent undertake to prevent unwanted pregnancy and has found that majority of the sexually active girls have never used contraceptives. The result of this scenario is that majority are victims of unwanted pregnancies that finally end up in backstreet abortions that are unsafe. This explains the poor health status of the ever pregnant girls who are either victims of early births or backstreet abortions.

Recommenations and Policy Implications

Adolescent sexually related behaviour as a dependent variable seems to be influenced mainly by short-sighted love which leads to increased sexuality. This in turn leads to early exposure to sex, multiple sex partners, unsafe sex, pregnancy and unsafe abortion. This in turn affects the girls future opprtunities e.g. better education, right marriage partner, marriage at the right age and a happy family life. The future health status of the girls is also negatively affected.

Early pregnancies largely occur among the less priviledged members of the society. The poverty situation in which they live includes low income, poor nutrition, high morbidity and mortality rates. This general apathy attracts attention and sympathy.

Adolescent sexuality has got a strong connection with lack of guidance and education in sexually related matters. This include the inability to obtain the necessary information from the right people such as parents, teachers and medical professionals. The adolescents respond to their sexuality by seeking clarification from their peers who are equally ignorant on sexually related matters. They also succumb to peer pressure .

Those who become victims of early pregnancy have no access to medically supervised abortion. They therefore seek abortion which is performed by the unskilled personnel with high risk of many side effects and deaths. Others choose to have illegitimate birth or enter into early marriages that become unhappy and unstable. These sexuality problems among adolescents are the

direct results of ignorance about responsible sexual behaviour. The unwanted pregnancies are due to ignorance about the nature of sexual intercourse and about contraception.

Adolescents who constitute a category of people that are still growing both mentally and physically should not be rated as adults. It is likely that adolescent fertility in Kenya is bound to increase and therefore any study or programme designed to deal with it should take note of relevant ethical and policy implications. Any actions pertaining to adolescent sexuality should be based on the concept of personal responsible sex behaviour and responsible parenthood.

The adolescent sexuality problem is especially sensitive in Kenya, since the younger generation is caught at cultural crossroads due to the gradual erosion of traditional values. Parents are no longer providing the counselling and guidance they used to in the past and the young people are becoming sexually active at an earlier age. Yet, the government, church, social and non-governmental organisations involved in family planning are reluctant to incorporate the youth in their programmes, let alone initiate a clear cut policy for them. A good illustration is the controversial television programme "Usiniharakishe" (do not hurry me into marriage) which was commissioned by the Ministry of Health and produced by the Kenya Broadcasting Corporation to address adolescent sexuality. This programme was taken off the air after two episodes as it was believed to be condoning sexual promiscuity.

The dilemma can also be illustrated by the unending debate on Population and Family Life Education in schools. An attempt by the Ministry of Education to have Family Life Education as a separate subject in the school curriculum has been faced by a lot of opposition, heated debates and demonstrations by the parents and religious leaders in Kenya. It is therefore evident that the youth problem in Kenya is a very touchy affair and because of this nobody wants to mention it. This leaves the adolescents with a lot of unsolved problems.

More research in the area of consequences of adolescent sexuality and fertility is needed as information available on this subject is scanty. However, in the 1990s a lot of information has come to air but not much has been done to handle the issues raised. In-depth research is necessary if the problem is to be properly understood and solutions found. The research findings should be used as a basis of suggestions on possible solutions and recommendations to a problem well understood.

When adolescents who give birth make attempts to return to school, attend vocational training or even indulge in prostitution, alcoholism and drugs abuse, they are making desperate attempts to subsist and to fend for their children. However, it is not necessary to disown those adolescents who have become victims of such circumstances. Rather, solutions must be sought in well-designed programs to investigate not only adolescent sexuality and fertility but the whole spectrum of adolescent life. The

adolescents do require support and guidance rather than condemnation and ridicule.

The severe socio-demographic and health problems facing adolescents are cyclical. Most adolescents in Kenya are born and raised in poverty. Their parents have limited education and few opportunities or resources for improving their conditions. The adolescent therefore pass on their plight to their children who are born unplanned, unspaced, under-nourished and unprovided for. This vicious cycle is repeated through early pregnancy.

To limit or minimise the epidemic of early sexual experience and the resulting early pregnancy in Kenya, policies should be issued that concern Family Life Education and responsible sexual behaviour. This will enable the adolescent to be equipped with the necessary knowledge in order to make responsible decisions related to their sexuality and subsequent childbirth. Those adolescents who choose to be sexually active should be provided with free access to contraceptive information and services. For this to be successful, information must be presented to young people before they become sexually active. The program should also aim at reaching as many adolescents as possible, most probably in a school setup. However, due to high rates of school drop-outs and low enrolment rates in some parts of Kenya, an out-of-school program would also be used to backup.

The need for Family Life Education Programmes for adolescent has been recognised and has been infused into the school curriculum. However, for a long time most of these programmes were

limited to the churches e.g. National Council of Churches of Kenya (NCCCK) and the Catholic Secretariat. The Ministry of Education has also come in since 1992 when some information on Population and Family Life Education was infused into various subjects taught in the school curriculum. These include Geography, History, Civics and Home Science in Primary schools and Geography, Homescience, Biology and Social Education and Ethics in Secondary Schools. There is however need to address ourselves to the youth who either do not enrol in school or who drop out of school very early.

Another recommendation is that the government could set up social programmes geared towards adolescents. Such programmes would include youth groups, church clubs and recreational facilities. Youth-to youth counselling programmes, so called peer counselling can also be encouraged. Career guidance and counselling is a crucial part of any successful adolescent programme. If a young person knows what he is aspiring for, he or she is likely to remain committed to that goal. Young people should be counselled early on careers and on what subjects to take. This will occupy their minds since they already know what they want in life right from an early age.

Adolescents who become pregnant should have antenatal services made accessible to them irrespective of socio-economic background. This can reduce substantially the serious complications associated with adolescent pregnancy. They should also be guided to avoid abortion and more so the back-street abortion. The government

should set up programmes that will cater for the emotional and other psycho-social problems that pregnant adolescents face. The adolescents who drop out of school due to pregnancy can also be provided with meaningful and economically productive work and dignified social roles should be made available to all adolescent women irrespective of their previous sexual behaviour. I do hope that the Youth Development Fund currently being raised by His excellency the President will assist this disadvantaged group.

Denying an adolescent woman formal educational opportunities because of pregnancy or birth as is practiced in Kenya is unacceptable. This only adds to the already high adolescent sexuality and subsequent early pregnancies as studies have shown that women with little or no education have high fertility.

The government should come up with policies that will ensure that adolescent girls who are sexually active are provided with family planning services. This will reduce the number of abortions performed every year. These services should include access to safe abortion in order to reduce abortion-related death and injury. Without new policies there may be more abortions in the future than ever before. The number of women who are killed or severely injured by unsafe abortions is likely to increase as well.

I do acknowledge that abortion is strongly opposed on moral grounds, but the attempts to ban the procedure will not stop the practice and are likely to cause great harm.

The challenge is great but with determination we can overcome these problems associated with early child bearing.

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