



Report

Unintended pregnancies and HIV among adolescents and young people

A situation analysis of
Homa Bay, Kenya

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Acronyms

AIDS	acquired immunodeficiency syndrome
AIHA	American International Health Alliance
ART	antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CRR	Center for Reproductive Rights
CSE	comprehensive sexuality education
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FBO	faith-based organisation
FGD	focus group discussion
FGM/C	female genital mutilation/cutting
FHE	family health education
FHOK	Family Health Options Kenya
GBV	gender-based violence
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDI	in-depth interview
IEC	information, education and communication
IGT	inter-generational trio
IHME	Institute for Health Metrics and Evaluation
KCCB	Kenya Conference of Catholic Bishops
KDHS	Kenya Demographic and Health Survey
KHPF	Kenyan Health Policy Framework
KII	key informant interview
KSPA	Kenya Service Provision Assessment
MCH	maternal and child health
MNCH	maternal, neonatal and child health
MSF	Médecins Sans Frontières
MSM	men who have sex with men
NCAPD	National Coordinating Agency for Population and Development
NCPD	National Council for Population and Development
NER	net enrolment rate
NGO	non-governmental organisation
NHSSP	National Health Sector Strategic Plan
NRHP	National Reproductive Health Policy

PEPFAR	US President's Emergency Plan for AIDS Relief
PrEP	pre-exposure prophylaxis
SARAM	Service Availability and Readiness Assessment Mapping
SRH	sexual and reproductive health
STI	sexually transmitted infection
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
VMMC	voluntary medical male circumcision

Foreword

Adolescent pregnancies are a global problem occurring in all economies. Annually, approximately 21 million girls aged 15 to 19 become pregnant in developing countries, of which approximately 12 million give birth. Over 700,000 births are recorded among adolescent girls younger than 15. Poverty and lack of education and employment opportunities in marginalised communities are common drivers for adolescent pregnancies. Homa Bay County has a very high prevalence of adolescent pregnancies, ranking second in Kenya. These high rates of teenage pregnancies have significantly contributed to poor health indices, including a high incidence rate for HIV that needs urgent attention from all stakeholders.

Major consequences result from early teenage pregnancies. The leading cause of death among girls aged 15 to 19 is pregnancy and childbirth complications. Additionally, unsafe abortions among these girls contribute to maternal mortality, morbidity and lasting health problems. In Homa Bay County, teenage pregnancies have significantly contributed to high HIV incidence rates, hampering efforts to fight against new infections. Early childbearing also has negative consequences for the newborn such as higher risks of low birth weight, preterm delivery and severe neonatal conditions. Other than health conditions, adolescent pregnancies are associated with both social and economic consequences such as stigma and rejection or violence by partners, parents and peers. They are also associated with girls dropping out of school after childbirth; a situation that jeopardises the girls' future education and employment opportunities.

In order for the county to respond effectively, this study was developed to aid in understanding the factors contributing to the high levels of unintended teenage pregnancies. This evidence about the factors contributing to unintended pregnancies in the county will contribute to efforts towards preventing adolescent girls from becoming wives and mothers and lowering the incidence of HIV.



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Executive summary

Reducing rates of unintended pregnancy and HIV is a major global challenge including in East Africa and in Kenya. Adolescent girls and young women are particularly vulnerable, due to various factors that include gender inequality, discriminatory gender norms, and lack of access to sexual and reproductive health (SRH) services and HIV prevention and information. Understanding context is key to designing effective interventions to help adolescents avoid unintended pregnancies and sexually transmitted infections (STIs) (including HIV) by improving access to SRH and HIV services.

This study looks at drivers of unintended pregnancy, HIV and violence among adolescents in Homa Bay County, Kenya, where teenage pregnancy is 33% for those age 15–19 and where youth aged 15–24 contribute 13% of the total number of HIV infections (among 15–49 year olds). The study also looks at the economic, social, legal and associated challenges faced by adolescent girls around unintended pregnancies and HIV. Based on a literature review and qualitative research conducted in 2019 with 112 adolescents (girls and boys, their parents, government officials and service providers), it aimed to capture differences in experiences, risks and vulnerabilities among those aged 13–15 years (mid-adolescence) and those aged 16–19 years (late adolescence). Research was conducted in two sites (one urban, Homa Bay Town, and one rural, Ndhiwa Constituency). Tools included in-depth interviews (IDIs), focus group discussions (FGDs), inter-generational trios (IGTs) and key informant interviews (KIIs). As well as capturing adolescents' experiences, it explores the policy and legal landscape, and government and non-governmental organisation (NGO) programming on SRH, HIV and violence.

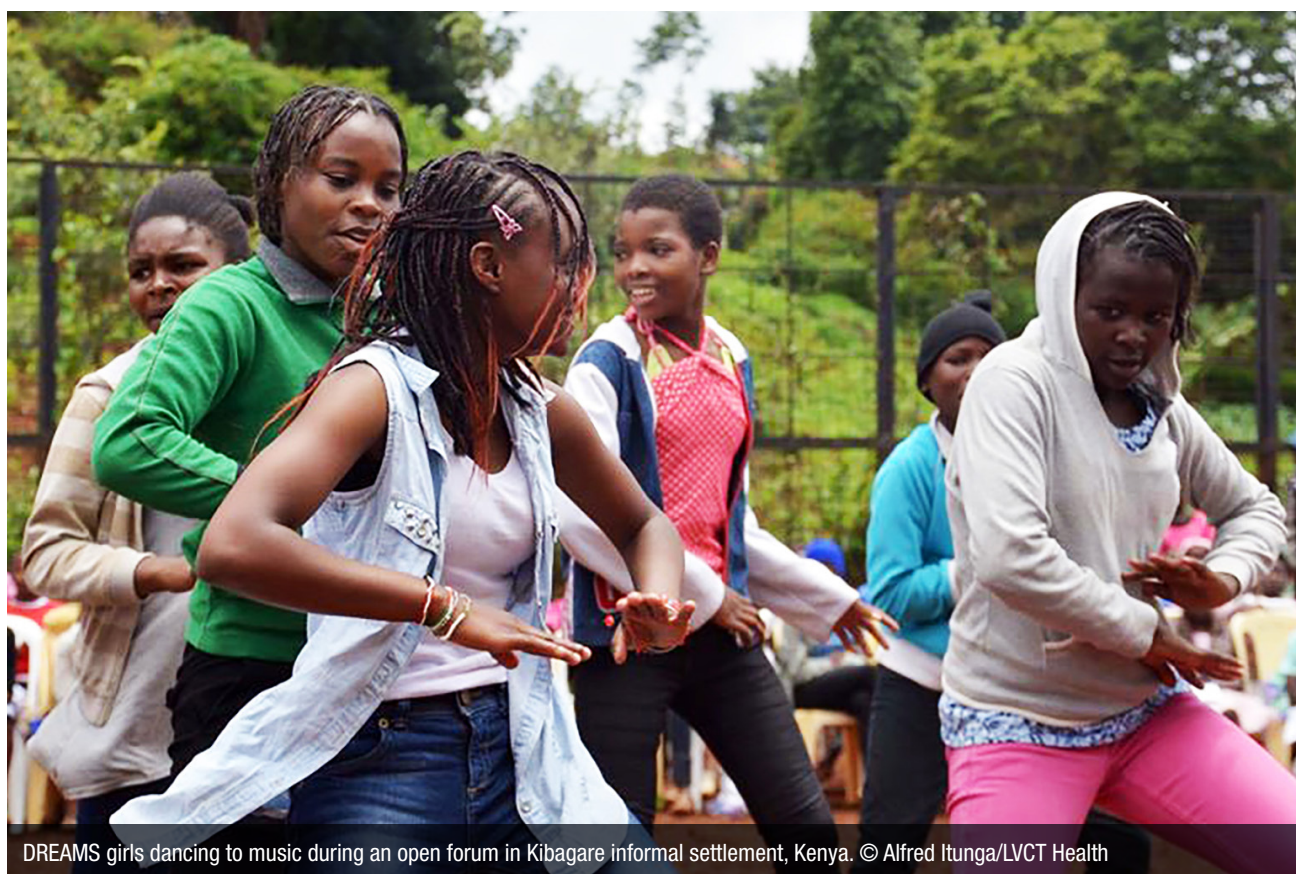
Findings

Legal and policy landscape

A set of policies and guidelines are in place to protect and respond to adolescents' health needs including those related to SRH – the National Adolescent Sexual and Reproductive Health Policy is one such policy. The Kenyan Constitution also references the specific health needs and vulnerabilities of adolescents. However, abortion is illegal in the Constitution and is only permissible if the case requires emergency treatment, or if the life or health of the woman is in danger. Other policies entitle victims of child sexual abuse to free legal and medical services and family health education (FHE). However, there are also a number of limitations: for instance, no reparations are offered to survivors of child sexual abuse; FHE is not systematically provided in schools; and there is a lack of multi-sectoral protocols at the national and county level outlining roles and responsibilities for various service providers.

Resource allocation

County-level budgets were not dedicated to specific population groups, including adolescents, but were broken down by programmatic areas, and adolescents benefited if they had the health problem being addressed (e.g. pregnancy, HIV, etc.). According to study respondents, most adolescent health activities at county level were donor-funded and were implemented by a range of partners who are members of the county-led adolescent technical working group, who target adolescent girls who are pregnant or have children, or adolescent boys and girls living with HIV.



Where do adolescents get information about SRH, HIV and violence-related services?

SRH services

Adolescents typically get information about SRH (including STIs, HIV and ante-natal/post-natal care) and violence-related services from a hospital, health clinic, school or NGO, but also from friends, the internet, parents, relatives, the radio and, to a lesser extent, the church. However, some adolescent respondents reported lacking adequate information on SRH and HIV for several reasons, and this appeared to be the case especially in Ndhiwa and among boys: they have little access to FHE at school or at home. This is because of laws and policies that restrict dissemination of such information but also due to negative perceptions, religious beliefs and stigma from their family, teachers, service providers, religious leaders and the wider community.

Parents noted that their adolescent children were unwilling to talk to them about SRH and HIV, nor did they feel comfortable discussing these issues with their children, preferring them to approach NGOs or schools instead. Abstinence from sex is the main message shared

with adolescents (by parents, teachers, health staff and ‘gatekeepers’ such as religious and traditional leaders), although health staff when approached or invited to schools are more able to share other information and inform adolescents about the services they offer. Some adolescents reported feeling uncomfortable approaching local clinics/health workers for information, preferring to use the internet, which offers more privacy.

Generally, respondents from both sites were more likely to access NGO programmes targeting youths for SRH, HIV and related services than to use government services. In terms of use of family planning methods, most adolescent respondents reported using some form of contraception, though not necessarily regularly. Irregular use among girls is due to lack of decision-making or negotiating power, perceived side-effects of contraceptives and fears of being stigmatised. The most common method used (both sites, reported by males and females) was the male condom, closely followed by short-acting contraceptives such as injectables and oral contraceptive pills. Contraceptives are nominally provided free of charge, though many facilities operated charges.

Although abortion is illegal, abortion services mentioned by respondents included those provided by hospitals, private clinics, NGOs or the use of herbal remedies. Some female participants had had an abortion or accompanied friends to have one. Reasons cited for not terminating a pregnancy include the fact that abortion is illegal; not knowing where to go; not having knowledge about the herbs and local remedies; fear of being stigmatised; associated costs; and religious or other personal beliefs.

HIV services

In both study sites, female adolescents stated that they were testing more frequently (every 1–3 months) compared to males (every 1–2 years). Most tests are conducted in outpatient clinics followed by voluntary counselling and testing (VCT) settings. Routine HIV testing for pregnant women attending antenatal clinics has played a major role in increasing testing among women of reproductive age in both sites. There has also been rapid expansion of antiretroviral therapy (ART) services across Kenya at public health centres and private facilities. All HIV-related services are free. Most study respondents who had used HIV services had received them from a government hospital or from an NGO; mobile health clinics also visit high-risk places (e.g. locations where sex workers operate) and there is door-to-door testing too. However, most respondents were not aware of HIV services that specifically targeted youths and HIV-positive respondents noted that the information provided in schools is incomplete. Other adolescents did not access HIV services due to fear of stigma from service providers, other students and school authorities, the wider community or extended family members.

Violence services

The hospital was known by female respondents from both sites as a place to obtain information and support in relation to violence. However, apart from reporting to the police and the local chief, respondents were not aware of support services for those experiencing violence. Some female respondents indicated that they have suffered and witnessed different forms of violence. Several women indicated that they did

not take any action due to fears of receiving more abuse; others who reported to the police or the local chief did not receive support and no action was taken against perpetrators.

The role of norms in driving adolescent behaviours around SRH and HIV

Norms play an important role in shaping adolescent behaviours around SRH and HIV. For example, norms around masculinity or faithfulness were reported to encourage sex without using a condom; norms around masculinity or femininity were reported to lead to sex with multiple partners; and norms around femininity were reported to encourage early sexual debut and sexual relationships.

Norms around relationships and sexual debut:

Age at first relationship as well as age at sexual debut, which appeared to coincide, was around 12–13 years among respondents in Ndhiwa and around 14–15 years for those in Homa Bay town; this was true for boys and girls, where first sexual encounters were largely with age mates and consensual. Reasons for early sexual debut included poverty, peer pressure from friends or boyfriends, and absence of one or both parents. In fact, our findings suggest that some girls are more likely to get pregnant than others, including: those from rural areas (who also have less access to information on family planning); those living in female-headed households; those who are unable to carry on studying (either because of lack of finances or because they failed exams); those escaping from violent households (often ending up marrying older men); and those from poorer households.

Norms and attitudes around early pregnancy

– intended and unintended: Most adolescent girls and boys noted that their pregnancies were unintended and the result of early relationships or sexual encounters. However, norms can align and intersect, sometimes leading to the emergence of new norms. In Homa Bay, a new norm towards teenage pregnancies being intended and accepted appears to be emerging. Many girls are getting pregnant in their early or mid-teens, partly driven by peer pressure to start relationships early and engage in sex. Early (teenage) pregnancy can also be seen as a rite of passage – for girls, demonstrating that they are desired by men, that

they are fertile and the ‘same as others’; and for boys, proving their masculinity and manhood. (This further explains some girls’ reluctance to use any contraception method, as some girls believed these could make them infertile.)

Having a child out of marriage is increasingly perceived as normal and accepted among our study respondents, particularly as girls have few employment opportunities and have neither the economic resources nor motivation to pursue higher education. In such cases, it now appears common for the girl’s mother to care for the baby while the girl is encouraged to return to school after giving birth. Family members, particularly mothers, appeared crucial in providing support for pregnant girls, with most respondents noting that even in male-headed households, emotional and practical/financial support comes from the girl’s mother. Interestingly, however, attitudes appear to change when it comes to having a second child outside of marriage – something that remains undesirable and certainly is not the norm.

In rural areas, stigma over adolescent pregnancy outside of marriage remains so strong that girls are sometimes sent away to live with extended family until after the baby is born. In some cases, girls do not return and relocate permanently with their baby to live with extended family members. Parents in Ndhiwa also felt ashamed or blamed themselves about their daughters’ pregnancies and avoided conversations beyond encouraging their daughters to return to school.

Norms around pregnancy and schooling:

Kenyan education policy allows pregnant girls to stay in school and to return after giving birth. Many of the expectant and new mothers in our study confirmed the active implementation of this policy, and most wanted to continue with their studies, with some reporting supportive teachers (especially female teachers) as well as support (mostly emotional) from peers. Pregnant girls who continued attending school after giving birth reported facing various challenges, including being unable to concentrate and ridiculed or made fun of by their classmates or staff. Girls who interrupt their studies typically do not have childcare support from their family.

Norms around marriage and cohabitation:

Most female respondents considered the ideal age

for marriage as 18 or older, whereas most male respondents talked about 20 or older. Reasons that could drive some girls, but also boys, to marry earlier than others include poverty, and lack of support from their family, particularly those who are orphaned and/or have an early pregnancy. Girls who married young (often to a man much older) are more likely to experience spousal violence yet have few options to escape, as they have usually dropped out of school, have become mothers, and have no income of their own.

Poverty and transactional sex

Poverty is another important driver of early sexual exposure and risky behaviours (e.g. multiple partnerships, drug use, intergenerational sex and casual sex, among others) that lead to unintended pregnancies and HIV. Adolescent girls and, to a lesser extent, boys indicated that they engaged in transactional sex with older men as sponsors because they lacked basic needs such as food, clothes, school-related expenses, transport or even emotional protection. Most of these adolescents were also from households where one or both parents were absent, while others were escaping from violence. Although some adolescent girls and boys engaged in transactional sex occasionally, others had no option other than to become sex workers.

Some girls (especially poorer girls and/or orphans) have one or more ‘sponsors’ or boyfriends from whom they would receive money or gifts such as clothes or mobile phones. It was reported that female friends had sometimes introduced them to a sponsor. Some of these girls are also motivated by peer pressure from other girlfriends who have sponsors and introduce them to potential candidates. Such relationships were regarded very differently from sex work, which is considered a job and is usually the person’s main occupation. It was also reported that adolescent boys had older female ‘sponsors’, and that this was accepted.

Risky behaviours (for HIV and unintended pregnancy)

Having multiple sexual partners, having casual sex, and intergenerational sex were seen as risky behaviours (the latter particularly affecting younger girls who may be coerced into sexual

encounters with older male relatives). Although it was not common among respondents, and while both female and male adolescents could have multiple sexual partners, it appeared more common among boys. While risky behaviours would be less risky if condoms were used, our data revealed that **condomless sex** is relatively common among youth in Homa Bay and Ndhiwa. Reasons range from very young boys not knowing how to use a condom, to girls not being able to negotiate that their sexual partner or boyfriend uses a condom, to girls being given (more) money for condomless sex, and to couples not wanting to use them, as a sign of a faithful relationship.

In rural areas, certain cultural practices (e.g. *disco matanga*, or disco funerals) also present risk factors for unintended pregnancy and HIV; such spaces not only provide opportunities for adolescents to engage in risky sex, they may also expose adolescent girls to unintentional violence and abuse from males under the influence of drugs and alcohol. Other attitudes (specifically ‘Yolo’ – you only live once) were cited as contributing to reckless sexual behaviour among young people in particular.

Policy recommendations

Policy-makers should regard adolescents as a key population group for SRH, HIV and violence-related services, particularly given current demographic trends.

Our research shows that adolescents are having sex without protection and that, in some cases, adolescent girls in particular lack family planning information but also decision-making power to persuade boys to use condoms, which puts them at risk of unintended pregnancies and HIV. Lack of information and access to services is more persistent in rural areas such as Ndhiwa. Cultural practices prevalent in rural areas such as wife inheritance and disco funerals were also perceived to put adolescents at risk of HIV and other STIs, and unintended pregnancies.

Addressing this in practice means recognising how adolescents’ SRH and HIV health needs change over the life course (from early to mid- and late adolescence) and the specific challenges

facing particularly vulnerable adolescents: those who are poor, or for whom other identities (gender, disability, geographical location, marital status, and sexuality, among other factors) compound their vulnerability. Adolescents at greatest risk of engaging in risky behaviours require specific policy and programming attention. They include orphaned adolescents, those living in poor or female-headed households, those fleeing violent environments, those who have been physically or emotionally abused, and those who are HIV positive.

Policy-making and programming priorities should include the following actions.

- Review FHE policies and implementation in schools, working with teachers, headteachers, education and health authorities at different levels.
- Disseminate age-appropriate information on SRH, HIV and violence-related services and programmes in schools, targeting younger (10–14) as well as older adolescents.
- Conduct awareness-raising with parents of adolescents (16 years and above), including information about SRH and HIV, existing programmes and how to discuss sensitive or embarrassing topics in an age-appropriate manner.
- Implement community-based awareness-raising programmes targeting community and religious leaders with information on SRH and HIV and the need for culturally appropriate FHE in schools.
- Support associations and community-based groups (or support the formation of new ones) that focus on dissemination of information and services related to SRH, HIV and violence.
- Balance messaging about HIV to reflect that while ‘HIV is no longer feared’, it is still important to avoid risky behaviours; messaging should avoid instilling fear and maintain the critical message that HIV is a manageable disease.
- Design programmes that encourage positive norm change and sensitise communities to reduce stigma towards adolescents, including those from marginalised groups, seeking SRH and HIV services.

- Target reference groups who uphold harmful norms as reaching these will be crucial to change gender norms and practices, particularly around unintended pregnancies.
- Ensure that programming for adolescents on SRH, HIV, GBV and gender norms is included in public budgets.
- Continue supporting and financing NGO programmes that address adolescents' GBV, SRH and HIV needs while also ensuring programmes align with government laws and policies.
- Raise awareness of existing policies at county level and nationally on SRH, HIV and violence-related services for adolescents.
- Ensure that policies and local institutions offer timely and effective recourse for adolescents who have experienced violence in the home.
- Review school health programmes on SRH and ensure that they are comprehensive, target appropriate age groups, and that teachers have sufficient skills and capacity to teach them.
- Include adolescents in the design of new policies and programmes.

Income security and livelihood opportunities

- Design and implement policies based on a life-course approach to provide income security to adolescents in vulnerable situations.

- Provide income security for the most vulnerable girls during their school years so that they can meet school-related expenses, through e.g. tailored cash-plus support package.
- Implement programmes (tailored to different contexts) that offer adolescents livelihood opportunities (training, education, skills development) to give girls alternatives to marriage and early pregnancy.
- Ensure greater financial support for adolescents in rural areas, who due to their greater economic needs are more likely to engage in risky behaviours.

SRH and HIV

- Ensure dissemination of relevant information and access to youth-friendly SRH/HIV services and programmes, with more training for staff.
- Provide family planning methods and supplies that are free and easily accessible in private spaces.
- Offer counselling and peer support for adolescents who are facing an unintended pregnancy and adolescents from vulnerable groups.
- Reduce the negative consequences of unsafe abortion practices.
- Ensure that programmes include boys and girls in order to promote greater awareness about services and programmes and begin to tackle gender norm change.

1 Introduction and background

Globally, adolescents (defined by the United Nations (UN) as individuals aged 10–19) make up 1.2 billion (or 16%) of the world's population (UNICEF, 2019a). Adolescence is a critical time for physical, social, cognitive and emotional growth and is also the stage when most girls and boys have their first sexual experiences. Adolescence is also when gender identities are formed, gender inequalities increase, and social norms – defined as patterns of behaviour that are 'motivated by a desire to conform to the shared social expectations of an important reference group' (Heise, 2013, cited in Marcus and Harper, 2014: 9) – become more rigidly enforced and personally salient (Marcus and Harper, 2015). These social norms often operate through a gendered lens and there is much evidence to show that adolescent girls are disproportionately disadvantaged compared to boys (e.g. Kabeer, 2018). Hence, while boys tend to have more opportunities and freedoms during adolescence, social norms often negatively affect girls' educational trajectories, economic opportunities and time poverty. Similarly, during adolescence, girls are subject to social norms that can bring early marriage, gender-based violence, and diminished physical and mental health, resulting in limited agency (Marcus and Harper, 2014; 2015).

Thus adolescent girls face numerous challenges in relation to sexual and reproductive health (SRH): they may be forced into unwanted sex or marriage, with high risk of unwanted pregnancies, as well as unsafe abortions, and contracting sexually transmitted infections (STIs) including HIV – all topics of interest to this study (UNFPA, 2013). Globally, the proportion of women aged 20–24 who were first married or in a union before age 18 was 21%; in eastern and southern Africa, this figure stood at 24%, while

in Kenya it was 23% (UNICEF, 2019b). From 2010–2015 in sub-Saharan Africa, over 45% of women aged 20–24 reported having given birth for the first time by age 18 (UNICEF, 2019b). The estimated adolescent birth rate globally was 44 births per 1,000 girls aged 15–19; in eastern and southern Africa, it was 92.1 per 1,000 girls (UNICEF, 2019c). Maternal conditions linked with childbearing were the top cause of mortality among girls aged 15–19 globally in 2018 (ibid.). Finally, adolescent girls are disproportionately affected by HIV: in 2019, 140,000 adolescent girls were estimated to be newly infected with HIV, compared with 90,000 adolescent boys (UNICEF, 2019d). Similarly, in 2018, only 19% of adolescent girls and 14% of adolescent boys aged 15–19 in eastern and southern Africa (the region most affected by HIV) have been tested for HIV in the past 12 months and received the test result (UNICEF, 2019d).

Overcoming the SRH and HIV-related challenges facing adolescents requires not only financial investments from countries and international partners in youth-friendly services and programming, but also effective implementation. Often, when strategies are not implemented effectively, adolescents are unable to obtain the SRH/HIV education and services they need to avoid unintended pregnancies, unsafe abortion and STIs. Similarly, overcoming attitudes, stigma and values linked to personal or religious/cultural beliefs can allow governments to deal with sensitive issues and biases, which act as key barriers in preventing evidence-based policy recommendations, and in translating these into effective implementation strategies (WHO, 2020).

As the Lancet Commission on adolescent health and well-being has noted in its seminal report, 'the most powerful actions for adolescent health

CITIZENS SERVICE DELIVERY CHARTER.			
VISION: A LEADING HEALTH CARE SERVICE PROVIDER IN THE REGION.			
MISSION: TO PROVIDE QUALITY PROMOTIVE, PREVENTIVE, CURATIVE AND REHABILITATIVE HEALTHCARE SERVICE WHICH IS ACCESSIBLE AND AFFORDABLE TO ALL.			
LABORATORY SERVICES		SERVICES	
UDRC TEST	30 MINS	REGISTRATION DESK	
MALARIA MICROSCOPY	100 30 MINS	• RECEPTION AND REGISTRATION	CO-OPERATION 5 MINS FREE
AAFB MICROSCOPY	150 10 MINS	• PASSBOOK ISSUING	CO-OPERATION 5 MINS FREE
HB TEST	200 30 MINS	• SPECIAL CLINIC FILES	CO-OPERATION 5 MINS FREE
WIDAL TEST	200 30 MINS	CONSULTATION	
BRUCELLOSIS TEST	300 30 MINS	• ADULTS / CHILDRENS ABOVE 5 YEARS	CO-OPERATION
H. PYLORI TEST	400 20 MINS	• CHILDREN UNDER 5 YEARS	CO-OPERATION
BLOOD GROUP TEST	150 30 MINS	• DRESSING	CO-OPERATION 100
URINALYSIS TEST	100 25 MINS	• STITCHING / INCISION & DRAINAGE	CO-OPERATION 500
STOOL FOR % TEST	150 15 MINS	• REMOVAL OF STITCHES	CO-OPERATION 100
RANDOM BLOOD SUGAR TEST	100 15 MINS	• CATHETERIZATION / REMOVAL	CO-OPERATION 100
PREGNANCY TEST	100 15 MINS	SPECIAL CLINICS	
RHEUMATOID TEST	200 45 MINS	MCH FP	CO-OPERATION
HIV TEST	45 MINS	• FAMILY PLANNING	CO-OPERATION
ANC PROFILE	45 MINS	• IMMUNIZATION	CO-OPERATION
COMPREHENSIVE CARE CENTRE (CCC)		• ANTINATAL CARE (ANC)	CO-OPERATION
CLIENTS ENROLMENT TO CARE		• POST NATAL CARE (PNC)	CO-OPERATION
ADHERENCE COUNSELLING		• PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)	CO-OPERATION
ANTI RETROVIRAL THERAPY (ART)		MATERNITY	CO-OPERATION
NUTRITION SERVICES		• DELIVERY.	CO-OPERATION
PHARMACY DEPARTMENT.		• POST NATAL CARE.	
DISPENSING OF MEDICATIONS		KEY POPULATION DICE	
		• RISK REDUCTION COUNSELLING	CO-OPERATION
		• DRUGS AND SUBSTANCE ABUSE COUNSELLING.	CO-OPERATION
		YOUTH FRIENDLY CENTRE	

Health centre services and charges, Makongeni sub-county hospital, Homa Bay County, Kenya. © Carmen Leon-Himmelstine/ODI

and wellbeing are intersectoral, multilevel, and multi-component' (Patton et al., 2016: 46). In several cases, evidence suggests that a combination of approaches is necessary for best results, as adolescents' SRH and HIV outcomes are determined by multi-faceted and interconnected factors that operate at various levels (Fatusi, 2016). Although there is no 'magic bullet', effectiveness of SRH/HIV interventions tends to depend on where and how an intervention is implemented. Thus, having a clear situational analysis that contributes to a better understanding of the context is key. This study aims to make such a contribution, exploring the context in Homa Bay, Kenya, where 33% of girls aged 15–19 years have begun childbearing (AFIDEP 2016) and youth aged 15–24 contribute to 13% of total HIV infections among adults (15–49) (Ministry of Health, 2020).

The purpose of this study is to explore the intersecting challenges facing girls around unintended pregnancies and HIV in Kenya's Homa Bay County. Drawing on previous research by UNICEF (UNICEF Kenya, 2017), reducing HIV infections in East Africa is a major challenge, and adolescent girls and young women are particularly vulnerable due to gender inequality, and lack of access to HIV prevention

and information services, among other factors. There are similar challenges in relation to SRH services, including unintended pregnancies (Starrs et al., 2018). This situation analysis aims to assist Homa Bay County, UNICEF and other partners to increase their understanding of the structural, economic, social and associated vulnerabilities facing adolescents and young people, so that they can develop more effective interventions around child abuse, unintended pregnancies and HIV.

This study is based on two main components: a literature review, and key findings from qualitative data collected in Homa Bay. The remainder of this section provides background to the study sites and an overview of the methods for primary data collection. Chapter 2 gives an overview of the legal and policy landscape as well as national programming on SRH, HIV and protection from violence, focusing on adolescents. Chapter 3 examines resource allocation for SRH and HIV programming in Homa Bay, exploring supply-side issues related to SRH, STIs (including HIV), violence and school-related programmes and services. Chapter 4 looks at adolescents' behaviours and perspectives, and investigates stigma around HIV, other STIs and SRH. Chapter 5 examines drivers of unintended pregnancy and HIV

among adolescents, including social norms and the linkages between poverty and transactional sex. Chapter 6 presents conclusions and recommendations for policy, services and other areas (including future research) to contribute to the realisation of adolescents' SRH rights and needs.

1.1 Homa Bay characteristics

Approximately half (48%) of Homa Bay County's population is aged below 15 (NCPD, 2015); nationally, half (52%) of the population is below the age of 20 (KNBS et al., 2014). Homa Bay County has a high total fertility rate of 5.2, compared to 3.9 nationally (ibid.). It also has the highest percentage of households with 4–6 members in the country, at 43% (Ngugi, 2013), compared to 38.5% nationally (KNBS et al., 2014). Homa Bay's young population has implications for the county's health and development agenda, placing high demand on the provision of services, including SRH (AFIDEP, 2016).

Childbearing begins early in Kenya, with almost one-quarter of women giving birth by age 18 and nearly half by age 20; 18% of adolescent girls aged 15–19 are already mothers; and 14.7% of 15–19 year olds have ever given birth (KNBS et al., 2014). In Homa Bay, 33% of girls aged 15–19 have begun child bearing, while 31.2% of the same age have ever given birth (KNBS, et al., 2014). Early marriage among girls is common (AFIDEP, 2016): half of all women in the county (aged 25–49 years) were first married by the age of 18, and half of all men (aged 30–54 years) had been married by age 24. National figures show age at first marriage (for the same age groups) as 20 for women and 25 for men. Factors such as age at first sexual intercourse, level of education, and payment of bride price are the most important in determining early marriage (i.e. before the age of 18) in Homa Bay (Ochieng, 2016). Finally, girls aged 15–19 in Homa Bay are approximately twice as likely to report experiencing spousal physical violence as their peers nationally, and are also approximately four times as likely to report experiencing sexual violence from their spouse (Undie, 2011).

Homa Bay's population is predominantly rural (75%, compared to 68% at national level) and of

Luo ethnicity. One in five county residents have no formal education, with Ndhiwa constituency having the highest share of residents with no formal education, at 22% (Ngugi, 2013). The county's primary net enrolment rate (NER) is 98%, compared to a national rate of 88%. The secondary NER is also higher than the national average of 47%, at 58% (AFIDEP, 2016). However, at secondary level, more boys attend school than girls in Homa Bay. The Basic Education Statistical Booklet gives disaggregated figures, and shows that primary school enrolment was 163,956 for boys (NER 98.2%) compared to 158,538 for girls (NER 98.4%); secondary enrolment was 42,847 for boys (NER 65.5%) compared to 31,606 for girls (NER 50.5%) (Ministry of Education, Science and Technology, 2014). In Homa Bay 39.7% of women have only some primary education – a higher proportion than the national rate (25.7%); for men, the figure is 28.3%, suggesting that women are more disadvantaged in educational outcomes in the region (KNBS et al., 2014).

Epidemiological data from Homa Bay describe the region as a 'hotspot' for HIV infection and early pregnancy (Neal et al., 2016). Homa Bay has HIV prevalence of 18.5%, much higher than the 4.5% for Kenya overall; in Homa Bay, prevalence is higher for women, at 22.5%, compared to 14.1% for men (the respective national figures are 5.2% and 4.5%) (Ministry of Health, 2020). Furthermore, in Homa Bay, the total number of youths aged 15–24 living with HIV is 16,474, while the total number of children aged 0–14 living with HIV is 11,965 (ibid.).

In terms of access to and use of contraception, more than half (56%) of currently married girls aged 15–19 in Homa Bay County use modern contraceptives, higher than the national average of 37% (AFIDEP, 2016). Government data also indicates that 69% of never married young women and 81% of never married young men aged 15–24 in Homa Bay used a condom during their most recent sexual encounter (ibid.). By comparison, nationwide, 27% of adolescent girls and 44% of adolescent boys who had ever had sexual intercourse reported using a method of contraception (Obare et al., 2017). Government data suggests that there is an unmet

need for contraceptives among married girls in Homa Bay, with about 1 in 10 (11%) of those aged 15–19 reporting that they would like to avoid pregnancy but are not using modern contraceptive methods, compared to 23% nationally (AFIDEP, 2016).

In Homa Bay County, 33% of girls aged 15–19 years have begun childbearing (*ibid.*), a figure which is considerably higher than the national average (18%) (Obare et al., 2017). Among 15–19-year-old girls, 2.1% are pregnant with their first child and 31.2% have ever given birth; the respective national figures are 3.4% and 14.7% (AFIDEP, 2016). Homa Bay County's adolescent birth rate (girls aged 15–19) is 178 births per 1,000 girls – about twice the national level of 96 per 1,000 (*ibid.*).

1.2 Methodology

Primary qualitative data collection was carried out between August and September 2019 by a team comprising members of the Overseas Development Institute (ODI) working with interpreters, LVCT Health staff, and an independent researcher. Piloting of the data collection tools, which were developed in a participatory way by all members of the study team, was carried out in Nairobi by members of the local team. Tools were then adapted further during initial interviews in Homa Bay County. Researchers collected data in two main sites: one urban, Homa Bay Town; and one more rural, Ndhiwa. These sites were selected by the Homa Bay County team because they both have higher prevalence of unintended pregnancy and HIV compared with other constituencies in the county. Selecting an urban and rural area would also allow us to explore how location may affect attitudes, behaviours and practices. In Ndhiwa, different wards were visited in order to elicit views from participants from a diversity of areas.

Qualitative tools (see Tables A1 and A2 in Annexes 1 and 2) included in-depth interviews (IDIs), focus group discussions (FGDs), inter-generational trios (IGTs – where different generations of the same family are interviewed) and key informant interviews (KIIs). Purposive sampling was used to enrol participants in the study, with support from the county health

team and in particular their social mobilisers. Recruitment of adolescents was largely carried out through health facilities, making use of existing linkages that staff had to potential respondents. A total of 112 respondents were interviewed across the two sites, including adolescent girls and boys, their parents/caregivers and service providers.

Approximately half the sample (58 of 112) were female; most (65) were aged 16–19 and were either single (39) or had a boyfriend/girlfriend (47). Forty-three had no children while several (35) had one or two children. Most participants (57) had completed some secondary education. In terms of main activity most were students (43), followed by those who reported not having a job (23), those who were farmers (10), casual workers (7), boda boda (bike/motorbike taxi) drivers (6), sex workers (5), business people (5) and fishermen (3). There was one electrician, one construction worker and one village elder.

Most participants lived in large households with several members of their family. Although there were a few cases of female-headed households, most participants lived in male-headed households. In these households, women had some role in decision-making, but key decisions were still taken by men (fathers, uncles or elder brothers). Most adolescent participants belonged to low-income households where parents did low-paid work such as farming, small trade, fishing, domestic work or construction. In addition to their income-generating activities, most women reported also carrying out the bulk of household chores and caring activities. In terms of religious affiliation, most participants (44) reported being Seventh-day Adventists, followed by Catholics (25) and other denominations (25). The religious affiliation of 15 participants was unknown.

With appropriate consent, all interviews were recorded, and then translated and transcribed. The study team jointly developed a coding structure, and all interviews were coded and entered into MAXQDA (data analysis software). Data from the coded segments was summarised according to agreed themes and the analysis also explored differences emerging from different variables, including site/location, gender, education, and relationship status. The analysis was then written up in the agreed report format.

As recruitment of respondents was mostly through a health facility catering for the health needs of adolescents, some respondents had a connection with facility staff (e.g. relatives of health or canteen volunteers). However, these participants still fitted the sample criteria and the research team triangulated the data (particularly through IGTs, KIIs and FGDs) to also obtain wider perceptions. Some participants had misreported their age to fit the sample criteria; however, the research team identified this issue from the beginning of the data collection, and decided to ask participants their year of birth to confirm their age. When participants did not fit the sample criteria, the interview did not proceed, and the research team recruited a new participant.

Other limitations emerged when recruiting key informants who were able and willing to talk about resource allocation for adolescent SRH and HIV services. While the research team conducted a few interviews in Homa Bay with relevant stakeholders, they did not provide the additional information that was requested, despite the research team's best efforts. Likewise, few stakeholders and partner organisations in Nairobi granted an interview or shared any information regarding their resource allocation for SRH and HIV programming. This is also understandable given the relatively sensitive nature of this information. Nevertheless, we still feel able to make the recommendations we make based on wider findings from the study.

2 Legal and policy landscape

This section provides a brief overview of the legal and policy landscape on SRH-related rights and services for adolescents and youth in Homa Bay County. It first provides an overview of SRH-related policies, then moves on to violence-related policies, and ends with other complementary policies. It is important to note that Kenya is a signatory to a number of international declarations and conventions, including the UN Convention on the Rights of the Child (UNCRC) (UN, 1989), the African Charter on the Rights and Welfare of the Child (Organization of African Unity, 1990), and the Programme of Action of the 1994 International Conference on Population and Development (ICPD) (UNFPA, 1994). These have formed the basis of the development of policies on adolescents' SRH rights as well as the definition of SRH-related services in Kenya. Indeed, during the ICPD Conference held in Nairobi in 2019, the President assured the audience of the country's continued commitment to achieve the goal of universal access to reproductive health services including prevention of pregnancies and HIV in adolescents by 2030 (President of the Republic of Kenya, 2019).

2.1 SRH laws and policies

Kenya was among the first African countries to formulate a population policy, in 1967, and established a national family planning programme under the Ministry of Health (Mumah et al., 2014). In 1982, the National Council for Population and Development (NCPD) was formed to coordinate all population and development research activities, as well as information, education and communication (IEC) programmes. In 1994, Kenya became a signatory to the ICPD Programme of Action,

which included pledges to achieve the goal of universal access to reproductive health services by 2015 (ibid.).

The Kenyan Health Policy Framework (KHPF) drew heavily on the 1994 ICPD and identified population growth management as a strategic imperative that was re-emphasised in subsequent National Health Sector Strategic Plans (NHSSP I and II). A National Population Advocacy Strategy and International Education Centre Strategy for Sustainable Development were established in 1996 by the NCPD. A National Reproductive Health Strategy (NRHS) for 1997 to 2010 was also developed in 1996, with the goal of providing a comprehensive, integrated system of reproductive healthcare through government, civil society organisations (CSOs) and private sector facilities. The ICPD also informed the development of the National Population Policy for Sustainable Development, which was approved by Parliament in 2000 and succeeded the Population Policy Guidelines of 1984.

In the mid-2000s, supporters of family planning within the new government contributed to expanding policy. In 2004, the National Coordinating Agency for Population and Development (NCAPD) was established to replace the NCPD, and Parliament allocated government funds toward family planning for the first time. In 2006, a Community Health Strategy was developed to improve access to health services and encourage uptake, including of family planning, at the community level. The following year, the Ministry of Health officially adopted the country's first National Reproductive Health Policy (NRHP), which laid guidelines for equitable and effective delivery of quality SRH services in Kenya, and stressed the need to reach under-served populations (Mumah et al., 2014).

In 2009, the guidelines for provision of family planning services were updated to ensure that service providers were up to date with information on methods of contraception. The 1997–2010 NRHS was also revised to ensure that inter-linkages between SRH and all other development sectors were properly identified and effectively addressed through a multi-sectoral approach. In 2012, Kenya adopted the new Population Policy for National Development to address rapid population growth and called for provision of reproductive health services that were youth friendly (NCPD, 2012).

Since 2000 several other relevant policies and strategies have been implemented (Mumah et al., 2014):

- The Contraceptive Commodities Procurement Plan (2003–2006), which resulted in an improved organisational structure for managing the procurement and distribution of contraceptives.
- A National Contraceptive Commodities Security Strategy (2007–2012) to ensure a continuous and affordable supply of contraceptives. Though this strategy has expired, the government has yet to develop a new one.
- The National Condom Policy and Strategy (2009–2014), which aims to ensure that every Kenyan is able to access accurate information about condoms and adequate supplies, irrespective of the person's geographical, economic or social status.
- The National Reproductive Health and HIV and AIDS Integration Strategy (2009), which sought to lay a framework for the integration of SRH and HIV services. Its goal is to increase access to comprehensive, high-quality, effective, efficient, affordable and sustainable SRH and HIV and AIDS services.

2.1.1 Adolescent-specific health policies

In 2003 the Adolescent Reproductive Health and Development Policy (Government of Kenya, 2003) was Kenya's first attempt at developing a policy that specifically targeted improvements in adolescents' health. Since then, statutes and laws have been developed that guide provision of SRH rights and services for adolescents,

based on the premise that they are a vulnerable group and need protection for their rights to be realised. Thus, in 2005, National Guidelines for Provision of Adolescent Youth-Friendly Services in Kenya were developed, which outlined an essential SRH services package for young people. It included: counselling; provision of information and education on reproductive health; training in livelihood skills and life skills; provision of contraceptives; screening and treatment of STIs, including HIV; voluntary counselling and testing for HIV; and comprehensive post-rape care. The 2007 Reproductive Health Policy also stipulated that adolescents should have full access to SRH information and youth-friendly reproductive health services and that a multi-sectoral approach was to be adopted to address adolescents' SRH needs. In addition, the 2010–2012 Reproductive Health Communication Strategy identified the provision of adequate information and universal access to SRH services as a priority for young people (Mumah et al., 2014).

The main policy document that currently guides provision of SRH services for adolescents is the National Adolescent Sexual and Reproductive Health Policy (Ministry of Health, 2015). The Kenyan government also recognises that while adolescents generally experience health challenges and have poor health outcomes, some have worse SRH outcomes than others, so need additional protection. The policy outlines several objectives and targets, including identifying the SRH needs of adolescents and providing clear guidelines to deal with their health concerns. Topics covered include: harmful practices, including early marriage, female genital mutilation/cutting (FGM/C) and gender-based violence; drug and substance abuse; socioeconomic factors; and the special needs of adolescents and young people with disabilities (Mumah et al., 2014). The adolescent SRH policy is currently being revised to include the specific needs of adolescents who are most at risk, which are not explicitly catered for in the current policy.

In addition to the adolescent SRH policy, there are other policies and guidelines (see Table 1) for adolescent health service implementation in Kenya, which aim to both protect and respond to adolescents' specific health needs and vulnerabilities. The HIV and AIDS Prevention

and Control Act (Government of Kenya, 2006a), for example, identifies ‘most at risk adolescents’ as those who are pregnant, married or parents, and those engaging in any other behaviour that puts them at risk of contracting HIV.

The presence of a relatively broad policy framework that guides provision of SRH services in Kenya has, however, not led to an improvement in the delivery of adolescent SRH services, and evidence indicates there is still unmet need for such services. Implementation of the policies at service delivery level has been weak and poorly coordinated resulting in inadequate provision and access especially for the hard to reach and

most vulnerable populations (Mutea et al., 2019). An assessment carried out in 2013 identified a number of factors that resulted in inadequate reinforcement of the policies, including low policy awareness, limited leadership, inadequate resources and lack of stakeholder engagement, especially youth involvement (Population Reference Bureau, 2013). The assessment identified seven recommendations to improve adolescent SRH policy implementation, including: (1) adopt an integrated approach to policy development and implementation; (2) improve leadership and coordination; (3) increase policy awareness; (4) improve implementation plans;

Table 1 Adolescent sexual and reproductive health-related policies and guidelines in Kenya

Policy/guideline document	Content summary
Kenya AIDS Strategic Framework: 2014/2015 – 2018/2019 (National AIDS Control Council (NACC), 2016)	Regards adolescents and young people as a priority population. Recommends combined interventions approach – focuses on changes in underlying structures through biomedical interventions.
National Adolescent Sexual and Reproductive Health Policy, 2015 (Ministry of Health, 2015)	Promotes provision of SRH services for adolescents in Kenya by mainstreaming their SRH rights in all health activities, including services and planning.
The Kenya HIV Testing Services Guidelines, 2015 (National AIDS and STI Control Programme (NASCOP), 2015)	Lowered the age of consent for HIV testing services to 15 years to enable access to services without parental consent for minors engaging in HIV-risk behaviour.
Guidelines for Conducting Adolescents Sexual and Reproductive Health Research in Kenya, 2015 (NASCOP and Kenya Medical Research Institute, 2015)	Recognises the importance of involving adolescents in SRH research and provides exceptions of parental consent for adolescents who are not under parental responsibility or may become vulnerable if parents/guardians are consented.
Kenya’s Fast-track Plan to End HIV and AIDS Among Adolescents and Young People, 2015 (NACC, 2015)	Recommends evidence-informed combination approaches to achieve goals that are expected to produce the highest returns on investment if implemented at scale.
The Kenya HIV Prevention Revolution Road Map: Count Down to 2030 (Ministry of Health, 2014)	Identifies adolescents and young people as a priority population for HIV services and recommends a location-based approach to service provision. Interventions identified include activities and services for protection and provision of SRH services.
National Guidelines for HIV/STI Programming with Key Populations (NASCOP, 2014)	Provides a framework to create an enabling environment and support adolescent key populations to reduce their risk of acquiring or transmitting HIV or STIs.
Sessional Paper No. 3 of 2012 on Population Policy for National Development (NCPD, 2012)	Recommends critical policy measures that can respond to most-at-risk adolescent programming – e.g. enforcement of rights and legal frameworks for protection of young people and multi-sectoral approach in responding with youth-friendly SRH services.
The Kenya National Children Policy 2010 (National Council for Children's Services, 2010)	Aims to prevent child abuse and neglect by providing recommendations that promote and protect the rights of children in health, education, and other socio-cultural aspects.
National Guidelines for Provision of Adolescent and Youth-Friendly Services in Kenya (Ministry of Health, 2005)	Provides a framework for improving coverage of adolescent and youth-friendly services through describing comprehensive services and outlining mechanisms for coordination, monitoring and evaluation.



Maternity ward, Malela Health Centre, Homa Bay County, Kenya. © Fiona Samuels/ODI

(5) improve resource mobilization and management; (6) improve service delivery; and (7) improve monitoring and evaluation.

2.1.2 Abortion laws and policies

Abortion is a significant reproductive health challenge facing women including adolescents in Kenya. A nationally representative study on abortion in Kenya estimated that 86% of women who presented in facilities for post abortion care were as a result of unsafe abortions, with 17% being aged 10–19 years old and majority (59%) being from rural areas. Severe complications of unsafe abortions (37% of cases of unsafe abortions) were most common among women aged 10–19 (45%) (Ministry of Health, 2013a).

According to the Constitution of Kenya, Article 26(4), abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law (National Council for Law, 2010). In accordance with the Constitution, the Health Act 2017 and the National Guidelines on the Management of Sexual Violence 2014, the following qualify for access to safe abortion services: a woman in need of emergency treatment; or whose pregnancy poses a danger to

her life; or whose health is in danger. The Health Act 2017 defines health as a complete state of physical, mental and social wellbeing and not merely the absence of disease (RHRA, n.d.).

In 2012 the Ministry of Health launched standards and guidelines for the reduction of maternal morbidity and mortality from unsafe abortion. These guidelines recommended that all centres providing sexual health services should be youth-friendly in order to reach as many young people as possible. The guidelines also defined several health providers – including medical officers, clinical officers, nurses and midwives – who, having completed the required training, could perform safe abortions in facilities that meet certain criteria (Mumah et al., 2014). These guidelines were withdrawn in December 2013 and are yet to be revised and reinstated.

The Ministry of Health national guidelines for quality obstetrics and perinatal care recognise abortion as a leading cause of maternal mortality and recognise post-abortion care among the six pillars of maternal and newborn health in Kenya (Ministry of Health, n.d.). The guidelines regulate post-abortion care (PAC) to include the following components: emergency treatment of complications from a spontaneous or unsafe induced abortion, family planning

counselling and services, access to comprehensive reproductive health care, including screening and treatment for STI, RTIs and HIV/AIDS; and community education to improve reproductive health and reduce the need for abortion.

2.2 Laws and policies on protection from violence

Violence against children and youth persists. Findings from the 2010 Kenya Violence against Children study indicated that among 18–24-year-olds, 32% of girls and 18% of boys had experienced sexual violence during childhood. The study also indicated that 66% of females and 73% of males had experienced physical violence during childhood, and 26% of females and 32% of males had experienced any form of violence as a child. Furthermore, 13% of females and 9% of males had experienced all three types of violence during childhood (UNICEF, 2012). The most common perpetrators were found to be boyfriends/girlfriends/romantic partners for females (47%) and males (43%), followed by neighbours (females 27%, males 21%) (ibid.).

Various institutions are tasked with promoting and protecting people's SRH rights in Kenya. For example, the Kenya National Commission on Human Rights undertook a public inquiry to investigate violations of SRH rights. The High Court presents another avenue for investigating SRH violations (Mumah et al., 2014).

Several NGOs also advocate for individuals' SRH rights. Such organisations include the Center for Reproductive Rights (CRR), which uses the law to advance reproductive freedom as a fundamental human right, and the Reproductive Health Rights Alliance (RHRA), with member organisations from the medical, legal, women's rights and reproductive health fields, formed to improve maternal health conditions. The Kenya Human Rights Commission, a national NGO, seeks to secure the pledges made under the constitution through advocacy initiatives and promoting the meaningful participation of citizens in governance and policy-making (Mumah et al., 2014).

Kenya's constitution guarantees adolescents protection from abuse and neglect, all forms of violence, harmful cultural practices, inhuman

treatment and punishment, and hazardous or exploitative labour (National Council for Law, 2010). Article 43 ensures that adolescents enjoy the right to healthcare, including reproductive healthcare. The 2006 Sexual Offences Act protects adolescents from sexual abuse – namely incest, defilement and rape. The Counter-Trafficking in Persons Act (2010) also seeks to guard adolescents from sexual abuse and includes tough penalties for offenders (Mumah et al., 2014).

As regards harmful traditional practices, the minimum age for marriage according to the Children Act, customary law and Sharia law in Kenya is 18 and all marriages should be registered to ensure compliance. Despite this, there is evidence of child marriages resulting from a combination of socio-economic and cultural factors such as poverty, adolescent pregnancy, and traditional customs (Girls not Brides, 2020). This calls for the need for more effective implementation of the Children Act.

Victims of child sexual abuse are entitled to free legal and medical services. However, there are no reparations offered to survivors in criminal proceedings and there is no legislation on age-appropriate comprehensive sexuality education. Child support agencies also have limited screening procedures, so there is a need to develop multi-sectoral protocols at national and county levels to outline roles and responsibilities for various service providers, supervisory and accountability measures and referral networks. For the relevant laws to be implemented, there needs to be practical guidelines on how to operationalise them. For instance, the Children Act stipulates that children's courts should be child-friendly but there are no guidelines on how to do this. Similarly, the National Standard Procedures for the Management of Sexual Violence Against Children provide inadequate guidelines for conducting forensic interviews (Wangamati et al., 2019). Overall, UNICEF (2018) indicates that despite legal frameworks to protect children from violence, abuse and exploitation, there are insufficient regulations in place to fully implement these laws. The report identifies capacity gaps in the social welfare workforce, such as lack of qualified staff and limited infrastructure. For example, the number

of children's officers is inadequate (only 1,073 children's officers across the 47 counties) and there are no institutional mechanisms in place to provide training on child protection issues (ibid.).

2.3 Other laws and policies

The 2001 Children Act (Government of Kenya, 2010), mentioned in the previous section, is one of several laws and policies that are of wider relevance to this study. The Act draws on the UNCRC and its four pillars of children's rights – the right to survival, protection, development and participation). Among other things, it identifies parents and the government as co-facilitators in ensuring that children exercise their right to health and education (ibid.). It gives parents responsibility for providing guidance to their children, which has been described as part of their 'parental responsibility'. Similarly, the National Council for Children's Services (2010) identifies the role of parents in their children's protection.

The 2010 constitution (National Council for Law, 2010), particularly Articles 21, 43(1) and 53(1), also recognises that every citizen has a right to the highest attainable standard of health and mandates public service officers and state organs to address the needs of vulnerable groups, including protecting every child's right to basic healthcare. Article 53(2) also stresses the importance of ensuring adherence to the best interests of the child in matters affecting them.

The Kenyan government calls for linkages between different actors responding to provision of services and protection of children's rights, such as parents, teachers, health providers and local administration officials. The Framework for the National Child Protection System (National Council for Children's Services, 2011) is an example of the government's efforts at

supporting multi-sectoral responsibility and creating linkages between stakeholders to promote children's rights. It identifies teachers as playing an important role in the provision of adolescents' SRH rights and information. It identifies local administrations as playing an important role in enforcing access to services, while parents and teachers are identified as important for provision of information and enabling access. Furthermore, the Kenyan government signed a declaration in 2013 committing to the provision of comprehensive sexuality education (CSE) in schools (UNESCO, 2013). However, a study on CSE in schools found inadequacies in delivery, with much emphasis placed on sexual abstinence and inadequate information around how to prevent pregnancy and STIs, and inadequate focus on gender and human rights issues (Sidze et al., 2017). This is also echoed in our study findings.

The first National School Health Policy (2009) defined a comprehensive school health programme to address the needs of students, teachers and their families.¹ It covered a wide range of health issues, including SRH and life skills that are key to supporting young people's health. The policy recognised the need to inform students on SRH and provide them with necessary skills to avert unwanted pregnancies, disease or sexual violence (Mumah et al., 2014). The policy has been revised to improve access to adolescent SRH with a focus on rights, stakeholder engagement and provision of comprehensive health services. The revised policy was launched in June 2019 and, in a bid to ensure effective implementation in the counties, various technical working groups are being set up, comprised of the Ministry of Health and Ministry of Education (Kenya News Agency, 2019).

1 The study team is aware of the existence of the second edition of the Kenya School Health Policy launched in 2019. However, at the time of writing this was not available electronically and, due to the Covid-19 situation, access to a hard copy in-country was not possible.

3 Resource allocation and SRH and HIV programme/service landscape in Homa Bay

3.1 County-level resource allocation, expenditure and health insurance

The Homa Bay County health budget is structured under four programmatic areas: (1) policy and planning/administration; (2) curative and rehabilitative health; (3) preventive and promotive health; and (4) research and development. Expenditure under these four areas can be recurrent or developmental, to cover capital/infrastructure expenditure and salaries/operational expenses respectively.

The county health budget for 2018/2019 was US\$25,351,000, increasing slightly to US\$25,983,000 for 2019/2020. It was reported that approximately 60% of 2018/19 expenditure was on salaries. Additionally, expenditure on development mainly focused on infrastructure for curative services as preventive services were in the community and required minimal equipment. In 2018/19 the amount budgeted for HIV was US\$430,000, while SRH was approximately US\$5,000,000. SRH was a lump sum that included maternal health, reproductive health, family planning, children and adolescents. This budget was given to the departments to split across curative and preventive services.

County budget decisions are made at different levels combining a top-down and bottom-up approach; however, most decisions tend to be made at higher levels. The County Assembly

determines funds allocated to the Health Department for the year following presentation by the County Health Minister (County Executive Committee Member for Health). The Chief Officer and Finance Officer determine how funds are allocated within departments.

Interviewer: Okay, and then who decides ... once you get your allocation, who decides how the funds are allocated, within here, within Health?

Respondent: The Finance Officer.

Interviewer: Finance Officer decides?

Respondent: Yes, and then the ... Director and then the Chief Officer (Key informant, County).

At both county and implementing partner level, it was reported that there was no specific allocation for adolescent health. Budgets were not dedicated to specific population groups but were broken down to programmatic areas, and adolescents benefited if they had the health problem being addressed (e.g. pregnancy, HIV, etc.). There was concern that most adolescent health activities at county level were donor funded, and that there was no specific budgetary allocation for adolescent health. When asked about spending on

adolescent services within the programmes that do not have a specific focus on adolescents, one key informant representing an HIV organisation reported that they spent approximately 20% of their budget on adolescent health:

I mean, it will be an extrapolation because when you look at the number of adolescents in care against the adults in care ... and try to arrive at a figure ... what goes to adolescents' work would be about 15% to 20% of the work because then the adolescents are still in the PMTCT [prevention of mother-to-child transmission] because the pregnant ones who are in care and the adolescents are in the health facilities that benefit broadly from the other interventions. The adolescents are also part of the VMMC [voluntary medical male circumcision] work, so roughly about 20% of the work would be around the adolescents and therefore the budget would be commensurate with that (Key informant, NGO).

3.1.1 Partner support and budgets

Many partners were reportedly working on adolescent health in Homa Bay County at sub-county or ward level. Some of those mentioned include LVCT Health, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), KMET, Family

Health Options Kenya, Marie Stopes, Médecins Sans Frontières (MSF), Plan International, Catholic Relief Services (CRS), Kenya Red Cross (G-Activate), and the Anglican Development Society. Their programming covered advocacy and communication, teenage pregnancy, education support through the DREAMS programme (PEPFAR – US President's Emergency Plan for AIDS Relief), youth-friendly centres/services, care and treatment, and support for adolescent technical working groups. These partners were members of the county-led adolescent technical working group, whose goal is to improve effectiveness and efficiency in the provision of health services to adolescents by providing a platform where relevant stakeholders provide updates on progress, share experiences, and develop partnerships. The group was a product of an adolescent health symposium that was held to discuss gaps in addressing HIV among adolescents in Homa Bay.

The county team worked closely with other line ministries, including Education, Youth and Gender, Interior and Coordination, the judiciary and police. These ministries were members of a multi-sectoral technical working group in the county that deals with teenage pregnancies and child marriage. The County Commissioner leads the multi-sectoral group and guides its action planning.

Adolescents receive SRH services through health programmes that either provide services to everyone or are targeted at adolescents. The latter specifically target adolescent girls who are

Table 2 Sexual and reproductive health services available for adolescents in Homa Bay

Adolescent category	Services available within SRH programmes ⁱ	Services not adequately available or provided with gaps (e.g. low coverage and/or limited resources)
Pregnant adolescents	Prevention of mother-to-child transmission (PMTCT) Sexual violation response services, including legal intervention services	Child protection services, especially availability of safe houses and support in litigation processes
Adolescent girls with children	Contraceptives Support with school re-admissions HIV Pre-Exposure Prophylaxis (PrEP)	Access to school subsidies
Adolescents living with HIV	HIV care and treatment Peer support from trained mentors	Youth-friendly services Health facilities that are within reach in rural areas
Adolescents from low-income households	School subsidies	School subsidies, especially support with tuition fees

ⁱ These services are only offered to adolescents enrolled in programmes or accessing services at health facilities. Additionally, not all adolescents receive the full services listed, depending on what the programme is able to offer.

pregnant or have children, or adolescent boys and girls living with HIV, as described in Table 2.

SRH programmes targeting adolescents also engage with other relevant stakeholders who are likely to influence the outcome of the services (e.g. those supporting HIV care and treatment ensured that their caregivers were engaged, while those supporting pregnant adolescents engaged their caregivers, the local administration and schools to enable the girls to resume school once they had given birth).

Implementing partners providing SRH services also engage with the County Health Management Team to share evidence on and provide technical support for best practices. Implementing partners also work together to provide complementary and integrated services. Finally, members of the county team reported not knowing partners' budgets for health (or adolescent health in particular), and they also reported not having a way of tracking it. However, they did recognise the importance of having this information to ensure sustainability of the interventions, particularly for when partners' presence ended:

... It is important for us to know the budget – for example, you know partners will go and then we'll remain, the Ministry of Health will remain. So we need to know how much we are spending. So that when we'll be budgeting, we'll also budget ... the amount which is adequate ... It is also important (Key informant, County).

3.1.2 Health insurance schemes

Respondents reported that most public health facilities were registered with the National Hospital Insurance Fund (NHIF) and Linda Mama (free maternity) schemes. NHIF is the national social insurance scheme whereby employees make mandatory contributions of varying scales while those in the informal sector join on a voluntary basis and pay US\$5 per month. NHIF allows beneficiaries to access services at registered public facilities at no cost (private facility costs are subsidised). Linda Mama is a national government scheme to ensure that all women can access free maternity services at registered facilities. For a woman to benefit,

she has to register for the card, which is free. The accredited facilities receive reimbursements through NHIF for all deliveries they conduct. In Homa Bay, it was reported that all the health facilities were registered with NHIF or Linda Mama, with the exception of two, which were in the process of registration. Neither Linda Mama nor NHIF have a specific focus on adolescents, but if they present for services and are registered, they would benefit.

One key informant reported that only about 60% of mothers going to NHIF-registered facilities were able to access the Linda Mama services. Home deliveries and lack of knowledge about the services Linda Mama offers were factors that resulted in relatively low utilisation of the insurance scheme:

There are some in the rural areas who are not aware – and remember, not all deliveries happen at facilities, some are at the private hospitals and some are at their home ..., UNICEF is actually catering for everything, but you find that the workload is very minimal. So this could be due to the fact that the public have not known that we offer such services (Key informant, County).

3.2 Programme/services environment

This section first outlines programmes and services on SRH, STIs/HIV and violence provided by government, NGOs and faith-based organisations (FBOs), focusing on services provided to adolescents. It then identifies school-based programmes. While the study also sought to examine programmes on gender norms, we could identify none in Homa Bay; one key informant mentioned that the technical working group has been working on programmes that challenge gender norms which predispose adolescents to gender-based violence, but we could find no further details about these programmes.

Before exploring the range of services, it is important to note that SRH and HIV services targeting adolescents are delivered through a multi-sectoral/stakeholder approach involving

different implementing partners (mostly NGOs) as well as the Ministry of Health. The space to discuss and coordinate strategies is the county's Adolescent Technical Working Group. According to the Chair of this group, partners and different ministries and authorities at the local level (e.g. Ministry of Education, Ministry of Youth and Gender, the judiciary and the police) discuss strategies to reduce teenage pregnancies and issues related to SRH. This working group is chaired by the Ministry of Health and meets quarterly.

Thus, according to key informants, the Homa Bay County government works with NGOs such as the Red Cross and UNICEF in the implementation of interventions. For example, the county coordinates with the Red Cross on implementation of awareness-raising activities on family planning and HIV; it also organises youth symposiums. Similarly, the government partners with UNICEF to train transporters (including *boda boda* drivers) in various parts of the county; SRH was mentioned as being included in the training. The Homa Bay Ministry of Health also partners with EGPAF, with funding from PEPFAR, to provide health services to the Homa Bay health facility of Makongeni. According to one service provider from this facility, the clinic is youth friendly and offers information and services on SRH, family planning, maternal, neonatal and child health (MNCH), HIV testing and counselling, adherence counselling and antiretroviral (ARV) treatment for HIV-positive patients, and referral services such as STI screening and treatment. This facility also targets key populations including sex workers, men who have sex with men (MSM), intravenous drug users and those who take part in 'sex for fish' trade (EGPAF, 2015). The clinic also offers abortion services to adolescents and young pregnant women in very limited cases, mostly when the mother's life is in danger.

3.2.1 Contraception, HIV and violence

Family planning and contraception

In 2004 and 2010, Kenya Service Provision Assessment (KSPA) surveys assessed the availability of family planning services in health facilities (hospitals, health centres, maternity facilities, clinics and dispensaries) at national



Display of family planning options; Malela Health Centre, Homa Bay County, Kenya. © Fiona Samuels/ODI

and provincial levels (NCAPD, 2005; Ministry of Medical Services, 2011). Thus, for Nyanza province (where Homa Bay is located), 85% of 690 facilities assessed offered modern methods of contraception (Mumah et al., 2014). According to Kenya's Service Availability and Readiness Assessment Mapping (SARAM) report, 83% of primary care facilities and 92% of hospitals were offering integrated maternal and child health (MCH) or family planning services (from a total of 180 health facilities assessed) (Ministry of Health, 2013). Family planning services in government facilities are supposed to be provided free of charge and there should be no charge for any government supplied commodities, whether obtained from a government or non-government facility. However, reports by KSPA indicated that most facilities charge some user fees, and these have been increasing over time (from 33% in 1999 to 70% in 2010). This was confirmed by service providers in Homa Bay, who noted that users pay fees for certain services and treatment, especially those that are costly (such as contraceptive implants).

The government is the largest provider of family planning services in Kenya, through the Ministry of Public Health and Sanitation, which in 2014 served more than half (60%) of

contraceptive users; 34% were supplied through private facilities (mainly private hospitals and pharmacies) and 5% through other sources (shops, mobile clinics and community-based distributors). Within the public sector, 24% of contraceptive users obtain their supplies from government dispensaries, 20% from government hospitals, and 16% from government health centres. Only 9.3% of female adolescents aged 15–19 who were sexually active were using a modern contraceptive method, 4.9% were using injectables, 2.5% were using male condoms, and 1.2% implants (KDHS, 2014). Kenya is increasingly involving communities, especially community health workers, in the delivery of family planning information and services, although they usually offer only information, counselling, and selected supplies such as condoms or pills, as well as counselling on the ‘lactational amenorrhea method’ and the ‘standard days method’.

Among the 2,356 facilities at national level and the 63 facilities in Homa Bay offering family planning services, SARAM does not indicate which of these are youth friendly (Ministry of Health, 2013). Relatively few health facilities in Kenya (10%) offer youth-friendly family planning services (*ibid.*). NGOs have led in implementing programmes to improve adolescents’ access to SRH information and services in Homa Bay. For example, the Population Council and Well Told Story (a Kenya-based social communications company) targeted married girls in the county between 2010 and 2011 to expand access to comprehensive information and services on SRH and HIV, for the girls (aged 14–19) and their partners (Undie, 2011).

Key informants also mentioned interventions by the Red Cross (in Rangwe, Karachuonyo and Suba constituencies) to raise awareness about family planning and STIs as well as antenatal care and HIV involving, targeting adolescents, their parents, community ‘gate-keepers’ (such as religious leaders or elders) and community health workers. Family Health Options Kenya (FHOK) is another NGO which provides youth-friendly services through health clinics in Homa Bay. Key informants also mentioned MSF as providing services on HIV and SRH to adolescents, although

little was known about their reach and impact. Finally, some clinics were mentioned as offering abortion services. Key informants and study respondents noted that adolescents also approach private clinics and herbalists who assist girls who wish to interrupt their pregnancy (see section 4.2).

HIV testing, care and treatment

According to the SARAM report, of 167 primary health facilities in Homa Bay that were visited during the survey, 86% offered PMTCT services and 88% offered HIV and STI prevention services. Similarly, among the 13 hospitals, all of them offered PMTCT services and 92% offered HIV and STI prevention services. Of a total of 180 health facilities, 84% were able to provide expected HIV services, given the availability of inputs (such as infrastructure, amenities, basic equipment, standard precautions for infection control, diagnostic tests, medicines and commodities) (Ministry of Health, 2013).

Nyanza region (as it was referred to when this data was collected), where Homa Bay is located, had the second highest levels of HIV testing (among Kenyans aged 15–64) in the country, at 80% (after Nairobi region, at 84.2%) (Ng’ang’a et al., 2014). The most common testing settings were outpatient clinics (44%) followed by voluntary counselling and testing (VCT) settings (30.2%). Routine HIV testing for pregnant women attending antenatal care clinics has played a major role in increasing HIV testing rates among women of reproductive age. Men who had been tested were more likely to have been tested in community-based settings (e.g. VCT facilities and mobile VCT) compared with other venues (Ng’ang’a et al., 2014).

There has been rapid expansion of antiretroviral therapy (ART) services across Kenya at public health centres and private facilities, and presumably Homa Bay mirrors this nationwide trend. ART patients reported overall satisfaction with services but also long wait times for care. Among ART patients seeking HIV care at public facilities, almost all had not had to pay medical expenses, reflecting Kenya’s national policy to provide free ART services at public hospitals and health centres. However, a large proportion of ART patients incurred transportation expenses associated with their

visit, which may be associated with travelling long distances to receive care (IHME, 2014).

However, the literature identifies certain barriers and limitations faced by adolescents in accessing HIV services in Kenya. Wilson et al. (2017) identified that inadequate provision of accessible and acceptable HIV testing, counselling and treatment services are barriers to uptake of care, and retention in HIV care, for adolescents and young adults aged 10–24. In particular, study participants expressed reluctance to seek care for fear of being judged by community health workers and because of perceived stigma and discrimination around HIV, as well as concerns over lack of confidentiality in healthcare settings. The study also highlights that adolescents and young people experience unique physiological, developmental and psychosocial changes that require services appropriate to their developmental stage.

As well as implementing programmes on family planning, NGOs have also led in the implementation of programmes to improve provision of HIV services for adolescents in Homa Bay, while also in some cases strengthening other areas such as health systems. FHOK offers HIV counselling and testing, targeting youth specifically, making referrals to public health facilities for HIV care and treatment. LVCT Health implemented the Most at Risk Adolescents (MARA) project between May 2017 and May 2018 (with support from UNICEF Kenya) targeting injecting drug users, female sex workers, men who have sex with men, adolescents living with HIV, as well as adolescents in the general population – all aged 10–19 years (UNICEF and LVCT Health, 2018).

The Red Carpet Programme implemented by EGPAF aimed to improve provision and uptake of HIV services among young people aged 15–21 in Homa Bay (Ruria et al., 2017). EGPAF also runs the Timiza 90 project, funded by the US Centers for Disease Control and Prevention (CDC) in Homa Bay, which provides comprehensive HIV prevention and treatment services to key populations, laboratory systems strengthening, VMMC, and care services for vulnerable children, while strengthening health systems for sustainable service delivery (EGPAF, 2019). Key informants

also observed that EGPAF provided the county with entertainment equipment for youths (including TV and a music system), as requested by local authorities. In addition, in June 2018, Plan International funded the Homa Bay Girls' Rescue Centre, whose facilities are within the EGPAF-funded health facility of Makongeni.

Likewise, the DREAMS project – implemented by the American International Health Alliance (AIHA) in collaboration with the Kenya Conference of Catholic Bishops (KCCB), and funded by PEPFAR – provides targeted support for adolescent girls aged 10–14 in the Homa Bay region. DREAMS consists of seven different evidence-informed behavioural, biomedical, and structural HIV prevention interventions (DREAMS, 2018).

Among our study respondents, there were, however, concerns that there were not enough programmes focusing on prevention of HIV among adolescents, and teenage pregnancy. Some of the existing programmes that attempt to provide such services were seen as not inclusive, as one key informant explained:

DREAMS is an individual-level intervention, it's not a community-level intervention; it still targets the girl as if the girl is an island ... A lot of work on adolescents has been driven by the HIV programme so that needs to be expanded so that the thinking around adolescent work looks at the adolescent development and well-being broadly, and that then will mean that there is a coordinated process that will ensure that health is dealing with the outcomes of pregnancy. (Key informant, NGO)

Finally, it was also reported that some projects supported activities inconsistently or irregularly, which limited their effectiveness. For example, some activities were carried out once a year instead of quarterly or monthly. Additionally, the County Health Management Team did not direct where partners would work and what area of work needed support, despite knowing the gaps in their county. This was noted as an area of improvement for the county stakeholder engagement:

What I would suggest to partners is to allocate themselves counties – for example, Red Cross go somewhere ... FHOK work in Suba ... But you know, sometimes our hands are tied because from their head office in Nairobi, they just come with a fixed plan ... (Key informant, County).

Violence

Evidence on recourse and services for survivors of violence in Homa Bay is extremely limited, whether for adults or adolescents. Although there is little or no data within Homa Bay County, according to nationwide data in the 2010 Violence Against Children survey (UNICEF, 2012), only 3 out of every 10 girls and less than 2 out of every 10 boys aged 13–17 told someone about an incident of sexual violence experienced in the previous 12 months. Availability and accessibility of services to support individuals who have experienced gender-based violence is limited, especially for adolescent girls, and women and girls who face multiple and intersecting forms of discrimination (e.g. those from marginalised communities, refugees, the elderly, sex workers, those living with HIV and those with disabilities) (UNICEF, 2018). Late reporting (or non-reporting) can be explained by stigma, fear of reprisals, and lack of capacity and resources on the part of different government agencies (e.g. police, health, judiciary) mandated to provide support (ibid.). Other reasons for non-reporting are explored in section 4.2.3. Furthermore, of those females aged 13–17 who had experienced sexual violence in the past 12 months, 8% reported receiving services (such as from a clinic or NGO) for an incident of sexual violence. Among males who had experienced sexual violence in the past 12 months, 2% reported receiving services for an incident of sexual violence (UNICEF, 2012).

In Homa Bay, it was observed that in cases of child defilement or other forms of violence towards children, action is taken and perpetrators who are convicted receive severe punishment. Key informants reported that children's officers and local administration/police were those most involved in enforcing the Sexual Offences Act. It was also reported that the severity of the

punishment increases according to how young a survivor is, although both parties would be charged in cases where those involved were minors purporting to have engaged in 'consensual sex'. However, it was also noted that the severity of the punishment did not act as a deterrent, since there has been an increase in defilement and under-age sex in the last few years:

Respondent: ... people do not learn. There is an increase in defilement cases despite the harsh sentences.

Interviewer: And over the years are you seeing that increasing in the other place?

Respondent: Yeah, it's increasing. The crime is on the rise (Key informant, Homa Bay).

Similarly, it was also observed that cases of defilement of under-age girls have increased in Homa Bay, particularly around school holidays, and that approximately 2–3 complaints were brought to the police each week. However, it was also noted that many cases go unreported, but when a case is brought, various agencies can provide legal and social support:

A large percentage of the cases do not arrive, they [adolescent girls] get pregnant in the village, they go on like that, but those who come to us, we receive the cases and then take legal action. Also, partners working in the villages, they come across these girls, they report to us. I even received some reports from school headteachers, I have some three girls who are pregnant, so those are some of the reports (Key informant, Homa Bay).

The literature identifies that in the case of post-rape care services for young people in Homa Bay, protocols are generally unavailable and health facilities were ill-equipped and poorly stocked (Wangamati et al., 2016). That study also noted that health service providers showed little regard for informed consent, confidentiality

and privacy while offering post-rape care. It recommended that providers and police receive training in sexual and gender-based violence, its consequences, as well as comprehensive post-rape care and SRH rights.

3.2.2 School-based sex education

School environments are important platforms through which SRH information can be provided to adolescents. Sex education in schools (and in the home) is reported to be inadequate in Kenya, with studies noting that few adolescents receive adequate SRH education, and teachers often lack sufficient training and information (Hussain, 2012; Sidze et al., 2017). Religious and cultural taboos are often seen to prevent open dialogue about premarital sex in schools and at home, even though such sexual activity is common, and even though students would welcome (for example) receiving education in school on how to use a condom (Juma et al., 2013).

The above challenges identified by the literature are confirmed by our study findings. Thus it was observed that teachers are not well trained to teach SRH and HIV topics and give information on those issues. Although teachers would like to receive further training, this is not supported by their schools. Some teachers based at Homa Bay and Ndhiwa offer counselling sessions to students on their own initiative, but they indicated this was rare. Some teachers offer information on family planning as best they can, but the messages they share are more around abstinence from sex.

These challenges are, at times, overcome by health clinics that offer programmes funded by international donors, through which the clinic is invited into schools to share information on SRH (e.g. FHOK or the Homa Bay Health Clinic of Makongeni).² Key informants from FHOK reported sharing information with students when they are invited by schools and they also train teachers and peer educators on skills related to

counselling, and educating adolescents about how to avoid pregnancy and STIs, including HIV. Similarly, the Homa Bay Health Clinic of Makongeni shares information with students about family planning, contraceptive options, and unsafe abortion (according to one service provider). However, information that is shared is based on age: for example, in primary schools, family planning topics are not covered unless facilitators identify any pregnant girl. For adolescents and youths aged 15–24 years who may be sexually active, facilitators emphasise condom use, other contraception options, and information about safe abortion facilities. However, if adolescents are under 15 years, facilitators generally stick to the message of reinforcing abstinence from sex, due to the government's policies:

... within the school, we emphasise abstinence, we don't talk about condoms or any formal family planning, we emphasise abstinence ... I can say it's like a government policy. They tend to believe that when you give information on sex and condoms, they [adolescents] start experimenting because that's the age that those girls and the boys are very curious. So, if they hear about something they'll try and test it and see how it is. So, when we focus on abstinence, we are trying to reduce that age of starting to engage in sex (Key informant, SRH and HIV testing service provider, Homa Bay).

Thus, abstinence from sex is the main message shared with adolescents by school and health staff alike, although health staff have slightly more freedom to share other information and to inform adolescents about the services they offer. Some teachers also pass on the contact information of health staff to students so that they can approach services directly.

2 FHOK is funded by the United Nations Population Fund (UNFPA), the European Union, the United States Agency for International Development (USAID), the Rockefeller Foundation, the Futures Group International, and the Swedish International Development Cooperation Agency, among others. The Homa Bay Health Clinic of Makongeni is funded by EGPAF and PEPFAR.

4 Sources of information, behaviours, and stigma around use of SRH and HIV-related services

This section explores adolescents' sources of information and knowledge about health services in general, as well as services related to SRH and violence. This is followed by a discussion on access to services, including role models and the role of social media in influencing behaviours, as well as the challenges faced when accessing such services. Finally, we examine adolescents' perceptions and stigma (experienced from service providers, teachers, the wider community, family, partners and individuals) related to SRH, including HIV and STIs. As part of this, we explore the role of religion and cultural practices, and any changes over time.

4.1 Sources and types of information and knowledge

The most commonly mentioned *sources of information for adolescents about general health services and products* were hospitals and the internet – the latter being particularly popular with those in tertiary education if they have a health concern or need information about medications or side effects. Other sources cited by adolescent respondents included family, friends, teachers, the radio, and church. Regarding *sources of information about SRH (including STIs, HIV and antenatal/postnatal care)* and related services, the most commonly cited source was hospital; the Homa Bay Health Clinic of Makongeni was also mentioned by

some participants but not all adolescents knew about the services it provided. Other sources were also identified by adolescent participants, such as the internet, services provided by NGOs (particularly the DREAMS initiative), school, friends, parents, relatives, the radio, and church.

Parents and key informants suggested that adolescents feel more comfortable obtaining information from their friends and from NGOs supported by partners (such as the DREAMS initiative). Some parents noted that they even preferred their children to approach NGOs because their staff are more knowledgeable about SRH and HIV than them, and because their children may be more open to talk in such spaces. However, adolescents received different messages from these sources. For example, the radio motivated some male adolescents to access circumcision services provided at the Homa Bay hospital (no specific programmes were mentioned). Parents and religious figures from different Christian denominations (e.g. Catholic) tended to encourage adolescents to abstain from sex (note that no other religions were mentioned).

Regarding the *types of services and products* that adolescents know about, in the case of family planning, the most common contraceptive methods cited (by males and females) were the male condom, closely followed by short-acting contraceptives such as injectables and oral contraceptive pills. Several respondents also cited the arm implant. When asked about the female



condom, none of the adolescent girl respondents had used one, and many had not seen one, although both males and females had heard of them. Furthermore, respondents stated that they were aware that condoms offered protection against HIV; this reflects various studies in Nyanza province and Homa Bay, which have found that most youths know that unprotected sex is the main mode of HIV transmission (Juma, 2012; Ooyi, 2015). However, condom use is not necessarily regular, as we describe further in section 4.2.

With the exception of a few girls in Ndhiwa – thus also suggesting that information about family planning may be less available in rural areas – most adolescent girls knew a variety of family planning methods, including one girl who mentioned the intrauterine device (IUD). Adolescent boys, however, mostly knew of condoms and were less likely to know of other methods, particularly those that females would use (and again, especially boys from Ndhiwa). Some male adolescents, including those with children, said they have heard from their female partner about contraceptive methods other than condoms and have been given booklets by their partner, but they appeared disinterested in knowing and/or discussing further. Knowledge and misconceptions

about these products differed. Some female respondents, including those who were already mothers, believed that some contraceptive methods had side effects (heavy bleeding, infertility, vaginal injuries) and so preferred not to use them. Meanwhile, one male adolescent in Ndhiwa also cited herbal drinks (using tree leaves or roots) that girls take for contraception.

Abortion services that adolescent respondents knew about included those provided by hospitals, private clinics, NGOs or the use of herbal remedies (although the question was on abortion, some respondents also spoke about post-abortion care). Female and male respondents alike noted that friends and relatives were also a source of information about abortion. Information about the costs of an abortion seemed to vary widely, from 500 shillings to 20,000 shillings (presumably depending on the kind of abortion obtained), according to respondents from Ndhiwa, and around 6,000 shillings, according to respondents in Homa Bay.

Most respondents were not aware of HIV services that specifically targeted youths. While some respondents were aware that they could access HIV services at the hospital, they were unsure if these were youth friendly. A few participants mentioned HIV testing services

provided door-to-door to all members of the household. Approximately half of adolescent respondents said they knew about *PrEP*; however, their knowledge was basic or/and they were unsure what it was for. Respondents among the most at-risk groups interviewed (drug users, sex workers, MSM) had largely heard about *PrEP*. Respondents who knew about it stated that, should they need it, it was available at the hospital and from NGOs.

In terms of knowledge about *government programmes and policies* targeting adolescents for health, SRH, HIV and related services, respondents from both study sites were most likely to refer to NGO programmes (e.g. Plan International or DREAMS). Most did not know about any government programme or policies supporting adolescents in relation to SRH or HIV. However, respondents under the MSM category observed that most government policies target female adolescents or those in heterosexual relationships, while NGOs implement programmes supporting adolescent MSM.

Concerning sources of information on *services to address violence*, the most common sources of help cited by adolescents were the police and the local chief, who, according to them, needed to be alerted when violence occurred (and a form needs to be filled out). While the hospital was mentioned as a place to obtain information/support, most female respondents from both study sites were not aware of any support services for those experiencing violence. Some female respondents in Homa Bay knew about the Makongeni rescue centre for victims of sexual violence, which is situated within the health clinic. In Ndhiwa, a few female respondents also mentioned a rescue centre, though they were unaware of its precise location.

A number of challenges were identified in terms of obtaining information and/or adolescents having limited access, specifically in relation to SRH. At the *individual and family level*, adolescents did not know where to access information, and this was true for both study sites. It was also noted by parents that their adolescent children were unwilling to talk about SRH with them and, at the same time, they felt unprepared for such discussions and preferred their children to approach NGOs. Service

providers also observed that the economic situation of adolescents and their families posed a challenge to accessing information: rather than attending sessions on SRH and HIV targeting adolescents, they preferred to engage in income-generating activities or activities for which they would receive an incentive or economic compensation.

At the *service delivery level* (including schools), some respondents stated that they felt uncomfortable asking health professionals for information about SRH, and preferred to use the internet, particularly Google search (though no specific sites were mentioned), which also offers them more privacy. Other respondents noted that accessing information from health services is time consuming, and when they do so over the phone, the information is often unclear. Those who reported attending sessions at health clinics noted that most of the information provided was for adolescents aged 15–18, and those aged under 14 felt shy or lacked the confidence to attend, which was also due to the attitudes of some health staff. It was noted that family planning topics are not allowed to be discussed at school, and some adolescent respondents reported not having enough information on family planning, including different kinds of contraceptive methods, the morning after pill, STIs, or even how HIV is transmitted. Additionally, respondents who were HIV positive noted that the information provided in schools is incomplete, particularly on HIV. While students receive information about HIV transmission, information about misconceptions and adherence to treatment is poor, therefore ignoring the needs of students who are HIV positive.

At a wider, *societal level*, perceptions of the types of information that should be shared with adolescents also influence access. For example, parents and key informants at the county government considered that adolescents should not receive information that could encourage them to become sexually active. Similarly, they noted that while adolescents could receive information about SRH, abstinence should be the main message – which, according to some adolescents, was unrealistic.

4.2 Behaviours/accessing services

Role models and social media were important in influencing adolescents' behaviours, including at times in relation to their use of SRH, HIV or related services. Family members, celebrities and friends were reported to be their *role models* and the most important individuals that influenced their behaviour. In the case of parents, both male and female adolescents referenced their mother as their role model, while male adolescents also cited their fathers and, less frequently, other male relatives such as grandfathers or older brothers. Parents were seen as role models because they influenced adolescents' behaviour – for example, in terms of 'being a good girl' or how to behave responsibly towards the family; they were also sources of advice on matters such as education, life choices or problems. Other role models included teachers, neighbours and religious leaders. A handful of female respondents from Homa Bay also cited celebrities as their role model (e.g. the actress Lupita Nyong'o and Kenyan politician Gladys Wanga) (they were perceived as 'hardworking, sociable and interested in helping their communities'). Other respondents suggested that they did not have a role model because they did not know anyone who was successful or wealthy enough that they could admire.

Friends were observed to play a different role in terms of influencing behaviour. As discussed further in section 5.1, friends influenced decisions about whether and when to have sex for the first time or whether to have multiple sex partners. There was, in fact, a thin line between role models and peer pressure. Others observed that their friends influenced certain life decisions: two sex workers, for example, suggested that the person who introduced them to their work was their role model, who was also their closest friend. Other participants observed that youths may also have negative role models at home or in their neighbourhood.

Increasing access to *mobile phones* was observed to facilitate behaviours around dating. For example, female and male adolescents indicated that they can easily arrange dates over the phone. Likewise, information related to dating (including pornographic videos) is shared

through social media, also influencing dating and sexual activity. According to adolescent respondents, social media can also increase peer pressure, with negative role models portrayed through TV and radio programmes.

The next sub-sections look in more depth at adolescent behaviours around the use of SRH and HIV services as well as violence.

4.2.1 Behaviours around use of SRH services

In terms of use of *family planning methods*, a minority of adolescent respondents, male and female, stated that they were not using any form of contraception. The most common method used was the male condom, according to males and females in both locations. However, female respondents in Homa Bay also mentioned using contraceptive implants and injections. Only one female respondent from Homa Bay stated that she had once taken the morning after pill. For older female adolescents who are married or in a relationship, according to a nurse at the Ndhiwa Health Clinic, the most common contraceptive method is injectables. Because this method is not visible, it creates the least amount of spousal tensions, since some male partners do not agree that their female partner uses a contraceptive method. The same nurse observed that implants are also preferred by adolescent girls since they are cheaper than other contraceptive methods.

Adolescents (males and females) indicated that they accessed contraceptive methods and services from a variety of places, most commonly the hospital, where contraception is provided free. Male respondents also mentioned collecting condoms freely from public dispensaries or purchasing them from pharmacies. Female respondents mentioned that they have access to condoms at school and sometimes they are distributed by NGO projects such as DREAMS. However, use of condoms and other family planning methods is not necessarily regular and from the first sexual encounter. At times, sexual encounters are unexpected, and on other occasions, perceptions around their use among adolescent themselves, as well as their families, plays a role in whether they will be used or not (see also below).

In terms of decision-making, our data suggest that the decision to use condoms (or not), at least

in the first relationship and in sexual encounters of adolescents, is usually taken by males (as explored further below). While adolescents have good knowledge on condoms and other family planning methods, and were usually aware that unprotected sex could lead to pregnancy and STIs, the potential consequences were apparently not considered in most cases, and respondents indicated that they were surprised when they learned that they (or their partner) were pregnant. Those who indicated a better understanding of potential consequences (including pregnancy and contracting STIs, including HIV) often chose to abstain from relationships altogether, waiting until they complete their education or training and have a regular income from a job.

Some female participants, especially those from Homa Bay, reported that they have had an abortion or have accompanied friends to have one. The most frequently cited place to go for an abortion was the hospital. Other respondents from Ndhiwa mentioned that they knew girls who took herbal remedies provided by local healers. There were also accounts of girls trying to abort using 'home-made' remedies: for example, one pregnant girl from Ndhiwa mentioned that she knew some girls who used washing powder together with Paracetamol and tea leaves. Parents were mostly unaware that their daughter was going for an abortion, with support coming from friends or close relatives that the girl could trust. For example, one male participant noted that when his girlfriend knew she was pregnant, she told him and her sister-in-law, who advised her not to have the baby (as both were students); the sister-in-law accompanied her to a private clinic she knew outside Ndhiwa. In a few cases, female adolescents stated that their mother encouraged them to have an abortion, but they did not proceed with it due to religious or other personal beliefs.

Participants stated that the decision to terminate a pregnancy was taken on some occasions by females but on other occasions by the male partner/father of the child. Reasons not to terminate the pregnancy, aside from the fact that abortion is illegal in Kenya, included: not knowing where to go; not having knowledge about the herbs and local remedies that could be used; fear of being stigmatised; and the costs associated with abortion.

All adolescents accessed free antenatal and postnatal care services – including pregnancy testing, delivery and postnatal check-up – at the hospital or a health clinic. Some pregnant girls mentioned that they would give birth in clinics where they can access Linda Mama (see section 3.1). Several respondents also stated that the hospital had given them a mosquito net for the baby. Only two respondents attended a private hospital. Most respondents described their experiences of using these services as average, with some noting a lack of staff. For example, one father-to-be at Homa Bay observed that at the hospital, health staff take care of adolescent patients 'in a hurry', and adolescent girls are not provided with tailored services they may need, such as counselling.

4.2.2 Behaviours around use of HIV services

Experiences of using HIV-related services differed among males and females. While a few male respondents noted that they had never had an HIV test, several males in both locations indicated that they had tested for HIV and that they test regularly (every one or two years). This was because they had been sexually active or because they perceived themselves to have engaged in risky practices, including, for instance, kissing other girls while having an open sore. Male adolescents from the most at risk groups – i.e. MSM and drug users – indicated that they test even more regularly (every three to six months); MSM also noted that they have used PrEP, although some do not use it regularly.

In the case of female adolescents, pregnant girls reported having an HIV test at the hospital, some for the first time, while others stated that they had tested before. Female adolescents stated that they were testing more frequently (every one to three months) compared to males. Some were motivated by practices that they believed put them at risk (e.g. sharing razor blades at school, having open wound injuries when kissing boys), and most were motivated by having recently engaged in sexual activity. Female adolescents from the most at risk groups, such as sex workers, also indicated testing often (every three months) and using PrEP, although not all participants indicated using PrEP regularly.

Regarding who took the decision to test, most adolescent respondents indicated that it was their own decision, while male adolescents suggested it was often their female partner who decided they should take a test. Decisions around testing behaviour were also driven by policies and programmes. Thus, sex workers noted that they are able to test regularly when the service is available in their workplaces (through vans which park in the hotels/bars where they work frequently). Similarly, students noted that they valued having HIV tests available for free in their schools, although this should be done with care to avoid stigma for those who tested positive. Adolescents also noted that they could test regularly because the service was free at hospitals, and staff were usually friendly and not judgemental.

A number of male adolescents also spoke about having accessed circumcision services as an HIV-prevention measure. This largely occurred when they were enrolled at school, when the push on male circumcision was at its height and schools were targeted for awareness-raising messages and activities. A number of adolescent boys spoke openly and unsolicited about having been circumcised. Several also mentioned that peer pressure also played a role in their decision to access circumcision services:

For me, at school, [circumcision] was more because of peer pressure. We were looked down upon by those who were circumcised. People would call us girls. But the parents were also talked into making us get circumcised (Male, 18, sex worker, Homa Bay).

All HIV-related services were accessed for free. Most respondents who had used HIV services had received them at the hospital. Other providers mentioned by respondents included NGOs (Plan International, LVCT Health), the government, through mobile health clinics visiting high-risk places where sex workers operate, or door-to-door health workers visiting households to offer HIV testing services. Health workers, according to one male HIV-positive respondent, target youths especially during the holiday period and offer counselling to HIV-positive adolescents and their parents. Other respondents from both locations

indicated that they were offered HIV testing services at school, although this experience was not always a good one:

In our school, those people would come, test people and then educate us on HIV. Those who tested positive were called to a separate place to be counselled. It was embarrassing because people would wonder why some people are left behind while others go their way. When you go there and ask them questions, some would be helpful, but others couldn't care less (FGD with HIV-positive females aged 15–19, Homa Bay).

Regarding respondents' experiences of accessing HIV services, the attitudes and behaviours of health workers played an important role, and the evidence is mixed, as we explore in subsection 4.3.1.

4.2.3 Accessing services related to violence

Some female respondents indicated that they have suffered and witnessed different types of violence, particularly physical and sexual violence. Perpetrators included relatives (mostly uncles or cousins), boyfriends, teachers, neighbours and, on some occasions, strangers who raped them during the night. Several women indicated that they did not take any action when they suffered or witnessed violence due to fears of receiving more abuse:

As a woman, sometimes you're forced to watch in silence as your husband physically abuses children because speaking out will lead to you being beaten too (Adolescent mother, 16, student, Homa Bay).

Other respondents noted that they went to the police or the local chief, but that they did not receive support, and no action was taken against the perpetrator. In some cases, the perpetrator even bribed the chief and local authorities or moved to another locality to avoid being found. Some parents were also reported to have reconciled with perpetrators without



DREAMS girls going through registration during a service provision and mentorship open forum in Kawangware, Kenya. © Alfred Itunga/LVCT Health

arbitration by local leaders, most likely to avoid situations of bribery or to find a faster method of reconciliation.

Fear of violence also led some adolescents to engage in unsafe SRH practices. For example, sex workers indicated that they agreed to have sex without protection due to fear of physical violence from their clients. Other girls indicated that they suffered violence from their partner when they refused to have sex, either without protection or at all. In the case of sex workers, they indicated that at times they go to the hospital to be treated but do not fill out a report against perpetrators because they would have to stop working, and they were unsure if perpetrators would face any legal repercussions.

4.2.4 Challenges in accessing services

Challenges (at the *individual and family level*) faced by girls often related to their lack of decision-making power over negotiating the use of family planning methods with their boyfriend or husband. Additionally, when faced with violence, some female adolescents reported not having anyone in their family they could trust and therefore not receiving any support. There were also reports of cases when girls told their

parents or guardians, but they did not believe them or ignored the situation, so could still not access any support. Also, some participants indicated that their parents were absent when they experienced violence, and they did not know who else to approach or were afraid to approach local authorities by themselves.

At *service delivery level*, challenges in accessing SRH services included: the lack of staff and resources to cater specifically for adolescents; and distance to health clinics and hospitals, particularly for those who need to get to hospital to give birth, and particularly for those in Ndhiwa. For example, one female respondent went into labour early in the morning and had no means of transportation to get to the nearest public hospital, so she had no choice but to pay a private hospital closer to where she lived.

At the *wider, societal level*, cultural and social beliefs of parents, service providers and the community in general influenced whether adolescents decided to access services such as family planning, the morning after pill or abortion. Furthermore, the policy and legal landscape also discouraged some adolescents from accessing services – in particular abortion, which was often denied to them by health staff. Even in cases of rape, health staff were reported to encourage adolescents to keep the baby:

The doctor said that if it is known that they have done an abortion for me they will be jailed. They just gave me encouragement and told me to just continue to go to school and not think about abortion. The doctors at the clinic told me that no teacher should make me stay at home because of the pregnancy ... They encouraged me and gave me examples and told me that there are other girls who, when they got pregnant, they committed suicide or disappeared, but that I should just feel encouraged and just stay around and keep the pregnancy (Pregnant girl, 13, student, Ndhiwa).

The most commonly cited challenge to accessing HIV services at this wider level was stigma:

Just going to the hospital specifically to get tested is very difficult for me ... I am just afraid that if I am found to be positive, the person testing me will look at me shocked that I have the disease ... So, I just don't go (Pregnant girl, 18, student, Homa Bay).

Other adolescents observed that they do not access HIV services because they fear that people may gossip about them if they are seen doing so. For example, in Ndhiwa, adolescents observed that HIV services are provided very close to the location of the general health services, which generates discomfort. Likewise, fear of stigma also affects adherence to treatment, particularly when adolescents are at school:

... youths are involved in lots of activities. Like in school, maybe your time for taking these drugs is during school hours. And you can't show the whole school you are sick. Word will spread like bushfire and you'll be stigmatised. We have not fully embraced and welcomed the population that is sick. So, youths struggle. Some take the drugs for a few weeks and decide they've had enough, so they stop taking those drugs ... It's youth who are hard hit by HIV and AIDS (FGD, HIV-positive males aged 15–19, Homa Bay).

The next section analyses perceptions and stigma in relation to SRH, HIV and other STIs from service providers, teachers, the wider community, family, and self-stigma.

4.3 Perceptions of who is at risk and of stigma

4.3.1 In relation to HIV and other STIs

Generally, findings from our study show that on the one hand, stigma around HIV and STIs may be declining, evidenced by (for instance) more people going for HIV testing. Similarly, male circumcision as an HIV prevention measure (not traditionally practised in the study sites) was also found to be relatively common among adolescent

boys, who were also relatively open about speaking about it, usually unsolicited. However, on the other hand, stigma remains. Furthermore, as HIV (as noted by study respondents) has become treatable and manageable, this can encourage risky behaviours among adolescents. Similarly, parents indicated several challenges in the attitudes of their children today (compared with previous generations), such as lack of respect and not listening to advice from adults. Changes in adolescents' attitudes were often framed as a driver for increased HIV and STIs and unintended pregnancies.

While none of our respondents identified the most common STIs (possibly due to language issues, in that they perhaps did not identify that category of infections with the term 'STIs'), there were a number of views expressed around who was most at risk. These included orphans, people living in poverty (as they had to engage in commercial sex for money), drug users, fishermen, and those who exchange sex for fish:

We're around the lake region. The HIV prevalence is high because the fishermen here have some [female] friends, they can give you fish in exchange for sex. Some of them are also ignorant about sex. They only think AIDS can be transmitted sexually. They don't know other ways of transmitting sex (Adolescent father, 19, boda boda driver, Homa Bay).

There were also some misconceptions, with some male adolescents believing girls were less at risk because their monthly periods 'helped them to clear out any STI'. However, other males also considered women were more at risk because genetically men are stronger and more resistant to STIs; this group of FGD participants also noted that girls took longer to identify STIs because their reproductive organs are hidden, and they may not even notice the symptoms.

In terms of *self-perception of HIV-related risk*, several male and female adolescents viewed themselves as being at particular risk due to unprotected sexual encounters. Although these respondents mentioned knowing that using protection or abstaining from sex were ways to

avoid getting HIV, there were somewhat fatalistic views expressed. As the quote illustrates, there is a view that in the end ‘everybody is at risk of HIV’ and there is relatively little someone can do about it, especially if one wants to keep the situation calm:

... you can’t know where your boyfriend has been, but you know yourself. These men think you don’t trust them when you ask them to go for a test. He’ll start talking badly and you’ll decide there is no need to create too much fuss over sex that doesn’t even last 30 minutes. And that way you’re at risk. Because even if you got tested together before, you can’t know his movements since then. So, everybody is at risk. I am at risk, so are you, and so are married people. Because the husband can infect the wife without her knowing and the wife can also infect the husband without him knowing. Everybody is at risk of HIV (Adolescent mother, 19, high-school student and small business owner, Homa Bay).

There was also a sense from some male adolescents of ‘passing the buck’ – suggesting that it was girls’ responsibility to get tested before engaging in unprotected sex. This was, to some extent, mirrored by female adolescents, who also considered it their responsibility to get tested; however, they also mentioned asking their male partners to test, although not all men reacted positively, as the quote above illustrates.

While several participants (none of whom were HIV positive) observed positive attitudes from health workers when accessing HIV services, HIV-positive participants reported negative or stigmatising attitudes. They felt they were looked down upon, not treated equally, and judged, and that there was also a lack of confidentiality – all of which made HIV-positive adolescents in particular avoid seeking HIV-related services, something which was also mirrored in Wilson et al. (2017).

Respondent 5: I don’t like it when a healthcare giver addresses me in English because it makes the session too formal

and uptight. Sometimes they need to loosen up and create a rapport to have us talking. Secondly, some of them are too focused on our HIV status that they don’t even talk about other issues like how to handle relationships as a positive person. All they talk about is HIV, condoms and whatnot.

Respondent 1: The health service provider should treat us equally, not look down upon us. Sometimes even when they give you food, they do it with so much attitude. They treat you that way because you have AIDS and they are clean. So, I think they should treat us as well as they would treat others.

Respondent 5: ... some of these health workers act like we are going to infect them with HIV even though they are wearing gloves. It’s really tormenting (FGD, HIV-positive females aged 15–19, Homa Bay).

Similarly, *HIV-positive respondents also reported experiencing negative attitudes and stigma in the school environment and within the wider community.* Some noted having to hide their status at school otherwise people would ‘not even give you a pencil’; they also noted having to hide taking their medication from their family. Young people in particular were noted as facing stigmatising attitudes when compared to older people, also because there was the perception that if they were HIV positive it was because they had engaged in under-age sex.

Respondent 6: ... sometimes you sit down with your new relatives ... Like for me, some of my relatives can come to visit me. And some of them don’t know I am HIV positive. And sometimes I put my drugs in a cupboard. What will make me struggle to go and get medicine is I don’t want them to see me taking the drugs.

Respondent 1: ... you may find it difficult to access those drugs when friends or relatives who may have come to visit you for maybe a week. So, it's hard for those youths. Elderly people can overcome such pressures but not youths (FGD, HIV-positive males aged 15–19, Homa Bay).

Respondent 5: I also wish there was a way to change people's perception of HIV. That would really help us because we wouldn't feel the need to hide it. I hope people would be educated about HIV (FGD, HIV-positive females aged 14–19, Ndhwa).

4.3.2 In relation to SRH

In general, use of family planning products and contraception by adolescent girls was not shared with family or friends because of fear of being judged and having to admit they were engaging in sexual relations. Reasons for not using any contraceptive method included fears that they would make the girl infertile or could cause side effects, echoing other studies (e.g. Machiyama et al., 2018). Other respondents, especially service providers, also noted that non-usage (especially of the morning after pill) was linked to fear of being stigmatised. Some male respondents stated that those who have a stable partner do not see the need to use condoms, while others believe they do not experience the same sexual sensation when using condoms.

Mirroring adolescent girls' fears about stigma, parents also had negative attitudes towards those using family planning as well as those providing the service, associating it with a number of factors, including encouraging sexual activity, sex work and long-term side effects:

Respondent 4: ... adolescent girls are initiated into contraceptive plans like family planning, the boys too are provided with condoms. Just like a last resort for a dying man. It's like they are told to go out and be prostitutes but take contraceptives so as not to get pregnant ... Same to boys, they are encouraged to have sex while

using condoms to protect themselves from diseases, which they contract anyway. So, we are not that happy with such services.

Interviewer: You say that you are not pleased, why?

Respondent 7: We could have been happier if our children were trained something on behavioural change. Family planning is not good for our children. It has several long-term side effects and we can attest to that. We are not happy with it. However, our hands are tied because if you persuade a daughter from using contraceptives, it only increases the chances of birthing even three children. That is a burden. We are not happy ... once they [adolescents] are given the condoms, a thought is already fed in their minds that they have to use the condoms. As a parent, I feel like our children are being misled. My only wish is that if there could be some youth centres that can teach about behavioural change so that they could focus on their future (FGD, married men aged 27–60, all with children, Homa Bay).

As also mentioned previously, parents expect and advise their children to abstain from sex. Parents and children rarely discuss relationships or family planning, with both parties feeling embarrassed to discuss such issues; when conversations do take place, mothers tend to take the lead. *Government officials also shared negative perceptions around adolescents under the age of 18 using family planning methods, but they also noted that they needed to have the information:*

They [adolescents] should be given the information, but they should abstain, they should have information because that is their right, talk about the rights of children, it is their right to get information at appropriate age but now you have to control it, they have to

reach the age of 18 ... (Key informant, government official, Homa Bay).

Religion was an important driver of attitudes and perceptions related to SRH. For example, several respondents highlighted that religious institutions encourage abstinence, although some indicated that a few religious leaders did provide information on family planning. Similarly, religious sponsored schools also encourage abstinence, as confirmed by service providers who are invited to schools to share information:

... some Catholic sponsored schools, you can't go there and talk about contraceptives and condoms. So, this will limit the access to information to these services. If you go there and start talking about condoms the first thing they will do is to chase you away. But then ... you don't give the information complete. I can't come talking about family planning and you don't want me to talk about the methods like provision of condoms and other methods, so how will that help? (Key informant, SRH and HIV service provider, Homa Bay).

Likewise, the view that those who had an abortion were committing murder was largely driven by religious beliefs, as expressed by several respondents, including adolescents:

I do discourage it [abortion]. If I post it in my WhatsApp status ... I do condemn abortion, I don't like it because I do caution them [people] when you abort you know you have killed. You have killed an angel. And there are repercussions (Adolescent father, 21, Homa Bay).

Although attitudes towards those using abortion services were predominantly negative, female adolescents also had negative perceptions towards abortion due to beliefs that it may be

the only opportunity they would have to have a child. Some parents also discouraged their daughters from having an abortion, offering to look after the child, even in cases of rape:

Interviewer: Why did your mum not let you have an abortion? What did she say? Why was she against it?

Respondent: She said that even my brother's wife gave birth while she was still in school and she [the mother] is the one who took care of the baby; until now, the baby is four years old. So, I just decided to keep the baby (Adolescent girl pregnant by defilement, 13, Ndhiwa).

4.3.3 In relation to violence

Negative perceptions among the community towards those who perpetrate violence against women and girls were observed. In the case of violence against adolescent girls, males indicated that girls usually suffer from physical, sexual and emotional violence, and also observed that they have seen cases of young girls marrying older men. However, respondents also observed that despite community disapproval of violence, they have not noticed any action taking place against perpetrators. Some female respondents indicated that when they tried to report cases of violence, the attitudes from chiefs were negative, sometimes accusing them of lying. Thus, they perceived that males in positions of power in the community were protecting other males.

According to one local government official, violence and sexual abuse of under-age girls are often not reported due to fears of stigma and prejudice from the wider community; this could also be because sometimes perpetrators are family members and there is fear that one of their own will be jailed. In terms of attitudes towards violence against sex workers, the data is limited. However, one sex worker indicated that violence against sex workers from clients is often deemed acceptable, and local authorities rarely intervene.

5 Drivers of unintended pregnancy and HIV among adolescents

This chapter explores drivers of adolescent pregnancy as well as HIV, examining the role of social norms, schools, poverty and risk behaviours.

5.1 The role of social norms in driving adolescents' SRH and HIV-related behaviours

The narratives of adolescent respondents reflect a variety of social norms which play a role in driving adolescents' SRH and HIV-related behaviours. These include: norms around relationships and sexual debut; norms around why girls get pregnant early and have (un)intended pregnancies; and norms around marriage and cohabitation.

5.1.1 Norms around relationships and sexual debut

Age at first relationships as well as age at sexual debut, which appeared to coincide, was around 12–13 years among respondents in Ndhiwa and around 14–15 years for those in Homa Bay; this was true for boys and girls, where first sexual encounters were largely with age mates. These relationships were mostly between school peers and neighbours, and were often the outcome of introductions between friends. First relationships and sexual encounters, for males and females, were mostly consensual; in a few cases, adolescent girls indicated having felt pressured to have their first sexual encounter with an older man, while in other cases, girls were reported by others as having been raped, particularly younger girls aged 10–13. Most respondents perceived their first relationships/sexual encounters as an

early exploration in this area – ‘a fun thing to do’ – without too much importance attached to it. Although several respondents suggested that these encounters were at times casual or impulsive, where they resulted in pregnancy, this may not always have been unintended, as we explore in sub-section 5.1.2.

Reasons for early sexual debut, according to study respondents, included *poverty* (with the aim being to obtain ‘something’ from the relationship) and *peer pressure*. Female and male adolescents both felt pressure from peers to have a partner because they ‘want to do the same, to look normal’, according to an adolescent father. For girls, peer pressure is often in the form of their female friends showing off gifts from their boyfriends, being given advice from girlfriends about starting relationships, or being introduced to candidates as boyfriends. Other female respondents indicated that they experienced pressure from their boyfriends, since ‘a girl who loves them [boyfriends] must have sex with them’. For males, peer pressure is often in the form of competitive masculinity or self-perceptions that not having a girlfriend was a poor reflection of their manhood. There were also some reports of male and female respondents starting to have sexual relations earlier (age 8–10 years); this was largely because of peer pressure and the desire to receiving money or material items.

Interviewer: When did you start having sex?

Respondent: At the age of 10.

Interviewer: And was it consensual or it was forced on you? How did you start?

Respondent: How I started ... I would see my female friends with their boyfriends ... When we were leaving school, I would see them [my girlfriends] with men. So, one friend would ask me how I had no boyfriend of my own. She told me I needed a boyfriend. I saw how they [men] could afford to buy mandazi [fried bread/donuts] snacks and they always had money. I decided I also wanted a boyfriend just to have money. That's where I started and had sex with him ... He was way older than me. He was even already done with school (Adolescent girl, 19, sex worker, Homa Bay).

Another factor that influences early involvement in relationships (especially for girls) is the *absence of one or both of their parents*. It was observed that adolescents whose parents were either working away or who had died often had no one to supervise them:

Another contributing factor [of early relationships and pregnancies] is parenting. For instance, being a single mother, I'm not at home from 6am to 9pm. I don't have time to sit down with my child and talk to and advise them (IGT, female, 39, sells vegetables, Homa Bay).

Adolescent girls were also often left in charge of younger siblings when one or both parents were absent, and with limited money, they often resort to boyfriends/men if they lack anything for themselves or their siblings. Others noted that as girls in rural areas have less information about SRH, it can lead to early sexual debut (and, in turn, early pregnancy), though it was also noted that girls in urban slums are also at risk.

In the case of boys, as girlfriends expect to receive gifts, items and food from their partner, boys that have some money to spend are more likely to have girlfriends at an earlier age. These

boys come from relatively well-off families and receive some money from their parents, while others engage in income-generating activities from a young age (e.g. small-scale trading, boda boda drivers, fishing).

Challenges in relationships include: cheating (by both sexes), though if a female confronts a cheating partner this can lead to physical and emotional violence. Financial challenges are also common among young couples with an early pregnancy, as young mothers often do not have their own economic resources and rely on their family's and boyfriend's support for childcare. However, in some cases, the boyfriends are still young and studying, and have limited financial resources.

Parents mentioned that nowadays youths have more freedom to make their own decisions, including those on relationships and sexual activity. They maintain that girls face very few consequences, as it is often the girl's mother who bears responsibility for taking care of the baby after birth, while the girl returns to school and carries on with her normal activities:

Respondent 8: ... In the olden days, when a girl got pregnant, she was to be given off to an old man. It made our girls keener not to get pregnant before marriage. So, instead of piling much pressure on the boys responsible for the pregnancy as it is always done, the girls too should face consequences for their actions. Because we all know pregnancy is voluntary unless it is a rape case, which should be taken to court. So, the girls should also face some consequences. We should change this so as to make our girls keen and responsible for their actions. It will reduce the number of teenage pregnancies. That will help us. The girl should also be held responsible. It will instill fear in them not to fall victims, unless it is a rape case (FGD, married men aged 27–60, all with children, Homa Bay).

Participants also identified new practices, particularly by fishermen and boda boda drivers,

as male adolescents and men who want casual sex lure young girls with fish, money or gifts, causing teenage early sexual debut, and resulting in pregnancies and possible HIV infection. Similarly, a focus group discussion with older women indicated that during their time, women ‘did not love money as these girls do now’, which influences young women to start dating younger or be promiscuous. Also, parents noted that in the past, if the girl became pregnant in a relationship, she was given to the man’s family, which made girls less keen to get pregnant.

5.1.2 Norms and attitudes toward early pregnancy – unintended or intended?

Respondents noted that it was common to see adolescent girls getting pregnant between the ages of 12 and 16. Our data also suggest that while some pregnancies are unplanned, others are planned. This is not necessarily expressed as such in respondents’ narratives but emerges when one starts to unpack the role of social norms and expectations underlying those narratives and discourses.

Most adolescent girls and boys (apart from two respondents) noted that their pregnancies were unintended and the result of early relationships or sexual encounters. Reasons given included that they did not use contraceptives (or did not use them regularly), and only once sexual encounters led to an actual pregnancy did adolescents decide to use contraceptive methods on a regular basis or to abstain from sexual relationships:

You know that kind of unwanted pregnancy is something that has hit me to the end and I cannot manage to get more girls pregnant currently. I’ve decided I want to cool off a bit, then I can start having girlfriends after that. Later, maybe at the university (18-year-old male student, Homa Bay).

Other participants noted that they lacked information on family planning from parents or schools and did not know where to obtain contraception. Similarly, some girls said they lacked decision-making power around contraception and

faced pressures from their boyfriend to have sex, which was often unprotected:

It didn’t cross my mind, I didn’t think I could be pregnant. I asked him if he was sure I have not gotten pregnant and he said there was no way I could be pregnant. So, I just let it slide like that (Pregnant girl, 18, student, Homa Bay).

It was just pressure. He kept telling me, ‘Why is it that you are always insisting that we use condoms? Or do you have other men outside?’ So I just gave in. He just didn’t want to use condoms, so I was forced to use without. After that I found myself pregnant (Pregnant girl, 18, student, Homa Bay).

However, as described earlier, adolescents are fairly well informed about contraceptive methods, particularly condoms, and know that condoms can prevent pregnancy and HIV. This suggests that to some extent they are ‘turning a blind eye’ to the possibility that they could become pregnant, which leads us to propose that *in some cases, teenage pregnancies could also be intended*. Our analysis indicates that different norms are interacting/intersecting in Homa Bay to make such pregnancies acceptable. One norm is around girls getting pregnant in their early or mid-teens, partly driven by peer pressure to start relationships early and engage in sex. Early pregnancy can also be seen as a rite of passage for girls where they can show that they are doing the same as their female peers, that they are desired by men and that they are fertile. This further explains some girls’ reluctance to use any contraception method, as some girls believed these could make them infertile (as discussed in sub-section 4.3.2).

While on the one hand there may be misconceptions around contraception, on the other hand, girls do have knowledge and information but some would still rather get pregnant to show that they are desirable, fertile and the ‘same as others’. There is also a tendency to emulate what has gone before – adolescents have seen older relatives having early pregnancies



Makongeni sub-county hospital, Homa Bay County, Kenya. © Fiona Samuels/ODI

and want to follow in their path, seeing them as some kind of role model. Hence, there is an intergenerational transmission of behaviours. This is not to say that some pregnancies may be unintended, reflecting girls' lack of negotiating power to avoid getting pregnant, as some of the quotes show. However, arguably there is something more complex at work here, where because of expected behaviours and norms around what it means to be a woman (and a man), girls feel they should become pregnant to prove themselves – to their female and male peers and the wider community – so for them, early pregnancy almost becomes intended and encouraged. This highlights the need (see 'Recommendations', section 6.1) for a multi-pronged approach to ensure that adolescents have accurate, easily accessible information but also the need for programmes to identify and addressing underlying structural factors, which include norms that can have negative outcomes for girls and young women:

She [the adolescent mother] has friends who had conceived earlier so they kept encouraging one another to get pregnant (IGT, male, 21, university student and does casual work, Homa Bay).

They [adolescent girls] copy from their relatives who had passed through that stage. For example, if a girl of their age gives birth, they may also like it and prefer giving birth at the same age (Participant in FGD with women aged 28–68, Ndhiwa).

Similarly, although boyfriends seem to have more decision-making power regarding contraception, some female and male respondents indicated that use of condoms could be interrupted in long-term relationships when trust between partners increases and where condomless sex is seen as a sign of a faithful relationship. Conversely, some respondents also noted that using condoms could be considered as proof that the boyfriend was being unfaithful.

Furthermore, as long as girls do not have two children outside marriage (see below), having one child while still living in the maternal home has become almost acceptable nowadays. Thus, the stigma of being pregnant and unmarried appears to have lessened; instead, a new norm is emerging where the mother of the adolescent girl now cares for the baby while the girl continues with her life and is encouraged to return to school. This practice appears largely preferable to the girl having an abortion, given that laws, cost,

fears of health repercussions, family/community stigma and/or religious beliefs are significant barriers. Finally, although no participant spoke openly about it, the lack of employment opportunities and/or inability to continue to higher levels of education may also play a role in the decision to get pregnant. Adolescent girls in particular see very limited work opportunities for themselves, so getting pregnant appears to be the only option they have.

Girls usually *disclose pregnancy* to their boyfriend/father of the baby first. When a boy finds out his girlfriend is pregnant, they disclose to friends and sometimes their parents. Girls indicated that disclosure usually happens early, such as when they find out they are missing their period. Sometimes, the father-to-be plays a role in helping the girl to confirm the pregnancy by advising and supporting her to get checked at the hospital or by buying a pregnancy test kit. Sometimes girls also reported discussing the pregnancy with their female friends or, on some occasions, their mother. However, there are also instances when girls do not disclose to anyone; in these cases, it is the girl's friend, mother or even boyfriend who notices the signs of early pregnancy and asks her to get checked.

Finally, as discussed earlier, some girls are more likely to get pregnant than others, including: those from rural areas (who also have less access to information on family planning); those living in female-headed households; those who are unable to carry on studying (either because of lack of finances or because they failed exams); those escaping from violent households (often ending up marrying older men); and those from poorer households (discussed in section 5.1.4).

Despite pregnancy sometimes being 'intended', becoming pregnant is still a cause for concern among girls. Some spoke about being worried about the reactions of their parents/guardians upon finding out they were pregnant (with some also not wanting to involve them – see quote below); others felt embarrassed, again mostly due to the reactions of their families and communities about having an early pregnancy. Others were worried about the effect it would have on their education, as well as their ability to support their child in future, especially without the support of the child's father:

I never wanted to bother anyone with my pregnancy other than the man responsible for it. I never wanted to bother my mum, my brother, my sister or anyone. I just managed to carry my own cross until the day of giving birth, because there, you need someone to help you. I have my close cousin. My mother is elderly. I didn't want to put her through having to bring me things (Adolescent mother, 19, student also with a small business, Homa Bay).

My biggest worry was that I didn't know how I was going to bring this child up. I was still in school, no job, no knowledge on how to take care of a child, I didn't have anything. You know someone who is in form three doesn't have a future yet. I had messed up my education. So, I kept wondering what I would do to bring up this child even if I kept it. How would I buy food? And the way the father had already dumped me. But there is a friend who came to me and told me not to have an abortion. She told me to just wait and give birth and then things will just work out ... I am no longer stressed by the fact that the father does not support me. The only stress I have now is how I will pay for his [her child's] school (Adolescent mother, 18, sex worker, Ndhiwa).

Thus, adolescent girls usually perceive that the responsibility of caring for and supporting their children financially falls to them (and their family, in some cases). Even though some boyfriends/boys do not take responsibility, several girls indicated they had not disclosed the identity of the father of their child because they feared parents and local authorities may have him arrested, and girls wanted to avoid any trouble and/or to protect the child's father.

The role and views of the girls' family change according to the stage of the pregnancy. Thus when families first found out about their daughter's pregnancy, they were often disappointed and angry (see Box 1). In rural areas especially, pregnant girls could be sent

away to live with extended family to hide the embarrassment of a teenage daughter having a child out of wedlock; once the baby is born, the girls either return to their villages with their babies or the family decides the girl and baby should remain with their extended family.

More generally, as the pregnancy progresses and once the baby is delivered, family members are central in providing support. The girl's mother was often critical in supporting with household chores before the girl was due to give birth and providing childcare and supplies (e.g. clothes, baby oil, soap) after the baby is born. Other family members, such as siblings and cousins, may also help with

chores during the pregnancy, and some also offer help with childcare. While for some girls, their fathers provide economic support, most family members mentioned that economic and emotional support usually comes from the girl's mother, even when these are not female-headed households:

I asked myself now that my teenage girl is getting pregnant at class seven, how will I take care of the baby that was to be born and how is she going back to school? ... My first concern was the cost of taking care of the baby, and again, I didn't know what the father of the baby

Box 1 Hiding a teenage pregnancy

Yvonne is a 15-year-old girl who is eight months pregnant and has been living with her maternal grandmother in Makongeni, Homa Bay, for three months. Her mother is alive but works long hours away from home. She had been living with her maternal grandfather and two siblings in Oyugis (a sub-county of Homa Bay), but was sent away to live with her grandmother when her grandfather discovered that she was pregnant. As she puts it: 'They didn't want my pregnancy to be publicised'. She has not told any friends about the pregnancy.

Although her grandfather didn't 'show any reaction' when she told him that she was pregnant, 'deep down [she] knew [she] had hurt him and he was angry though he didn't openly show it'. He forbade her from seeking an abortion, including through 'very strong tea or concoctions because that would ruin [her] life and health'. She attends a Seventh-day Adventist church.

Yvonne is in class 8 and her boyfriend (the father of the baby) is in form 2. They were neighbours and met (it is implied in secret) when she was sent out to the shop. They have been in a relationship for around a year. Her boyfriend used to buy her clothes and sometimes gave her money (around 100–200 shillings). He was a student and would share his pocket money with her, so that she could buy herself lunch at school rather than go home for lunch (which made her late for afternoon lessons as she walks a long way to school).

They first had sex when she was 14 years old; he would 'sneak' into the house when her grandfather went out for a walk and her siblings were playing outside. He sometimes refused to use condoms, while she felt that people might talk negatively about a girl under 18 (i.e. not of marriageable age) accessing contraceptive services at health centres. She has not had any other sexual partners. After giving birth, she plans to get an injectable contraceptive.

Yvonne informed her boyfriend of it two months into the pregnancy, but he 'denied' responsibility and they haven't been in contact since. She hasn't told her grandfather who the father is (although she says that he knows the boyfriend) because 'he is hot tempered and could have beaten that boy and injured him badly'.

Yvonne had already registered for the national exam when her family found out she was pregnant and will return to Oyugis to sit the exam after giving birth. Her grandfather has also arranged for her to move to Migori, where her stepmother lives for her secondary school studies. Yvonne says she doesn't know who will support her after the baby is born but expects that the stepmother and possibly her biological mother will help.

was thinking about the pregnancy (IGT, mother of pregnant girl, age unknown, farmer and casual labourer, Ndhiwa).

Some fathers indicated they had not spoken to their pregnant daughter (as some felt ashamed or blamed themselves for the situation), apart from telling her of the importance of returning to school:

... I didn't say anything, I just left things as they were ... We just sat her down recently now that she's preparing to go back to school and talked to her and told her not to do that again and that she should study (IGT, father, 32, farmer and casual labourer, Ndhiwa).

When *adolescent boys and fathers-to-be* first found out about the girl's/girlfriend's pregnancy, they sometimes reacted negatively, fearing reactions of their own family and being arrested for getting a young girl pregnant. Those who informed their families also noted that their parents (particularly the father) decided whether they would support the girl or not. Reactions of parents or guardians upon hearing that their son was a father-to-be ranged from disbelief, to demanding that they end the relationship and focus on school. Some fathers-to-be themselves decided not to take responsibility and stopped communicating with the girl. Similarly, some indicated denying their involvement with the girl and feeling relieved once the girl relocated to another village, particularly girls from Ndhiwa.

You know, all this is based on the parents' view or consent because as I told you, the parents do not welcome the issue ... Due to low income for most Kenyans, early pregnancies or unwanted pregnancies aren't something that we want to embrace so much (Father-to-be, 18, student, Homa Bay).

When he [father of the child] realised, he didn't accept it and he was very angry. Because he was from a well-off family, he decided to abandon me. When I informed his parents, they were

so angry at me for accusing their son for something he's not capable of doing. So, he decided to go and I decided to let him go (Pregnant adolescent girl, already with one child, 16, student, Homa Bay).

My dad gave me two options: go to school or drop out. I told him that I was sorry, that I had made a mistake and that I wanted to continue with school. I decided to go back to school. So, my father said if I want to go back to school, I should focus on my school ... He told me to stop that relationship completely (Father-to-be, 15, student, Ndhiwa).

Boys who stayed involved with their pregnant girlfriend did so to varying degrees. Some accompanied the girl during the pregnancy (e.g. visits to the hospital), while others remained in a relationship with the girl and/or married her (in a few cases, at his family's suggestion, as a way of taking responsibility). In a couple of cases, boys noted that they provide financial support occasionally (including sending infant supplies); these boys were usually in their late teens and working part-time or full-time. Usually, if the boy is still in school, his family (if the boy and his family decide to get involved) will send some financial support occasionally, as one girl indicated:

When I gave birth, I can't deny he supported me. He gave me support because he also can't reach the level a parent can. He also depends on his parents. You know, you can't force things. But in most cases when he gets money, he can send around 500 shillings to buy the baby's diapers or milk. But he doesn't send it every month (Adolescent mother, 19, student and has a business, Homa Bay).

Most study respondents noted that the community held negative views towards teenage pregnancies, and a pregnancy would not usually be disclosed until it is visible (as seen also with adolescent girls being sent away while pregnant).

Thus, both adolescent girls and their families in Homa Bay and Ndhiwa stated that it was very common for neighbours to gossip about early pregnancies and speak negatively behind their backs that a young girl is having a child out of wedlock. In Ndhiwa in particular, pregnant girls felt ashamed to walk around or to attend school for fear of being mocked or receiving aggressive comments or behaviour from members of the community:

You would find, like, for example, if I asked someone to fetch water for me, instead of fetching they throw my bucket away (Adolescent mother, 19, sex worker, Ndhiwa).

However, there were also accounts of some friends or neighbours helping with chores and providing supplies when the baby is born or during his/her first years. However, it is expected that girls with children finish their education and get married before having more children.

When adolescents were asked what they would have done differently to avoid early pregnancy, some mentioned they would have focused on school rather than on relationships. Others said they would have used contraceptive methods from their very first sexual encounter. A few also mentioned that they would have approached someone who could guide them, such as elders, teachers or relatives. More generally, however, adolescent girls did not appear to regret the decision to become a mother in spite of the challenges they faced and, in most cases, the girl's parents or family ended up accepting the pregnancy and supporting the girl and her child, though also encouraging her to continue studying and abstain from sex. Furthermore, motherhood was viewed as critical for girls/women; while being a parent was considered more important (by adolescent males and females) than being a spouse, our data also suggest that having children is slightly more important for women than men. For instance, some adolescent girls in Ndhiwa noted that having children 'is a must because you need someone to help you take care of the home'. Other girls, also from Ndhiwa, noted that 'a mother is the foundation of a home' or that 'some people can insult you if you don't [have children]'.

Most of the respondents (male and female) who were already parents indicated that they wanted to have more children in future, sometime in their twenties, when they have completed their education (and, for boys, when they find a job and have financial stability). However, in very few cases, respondents considered having more children with the father/mother of their child, unless the relationship was continuing with the same person. These views indicate that having children with more than one person is not necessarily frowned upon, unless a woman has children with several, or more than two men, as participants indicated.

5.1.3 Norms around pregnancy and going to school

As already discussed, there is an expectation that pregnant girls will continue going to school. According to study respondents, Kenyan education policy allows pregnant girls to stay in school and to return after giving birth. Many of the expectant and new mothers in the study confirmed the implementation of this policy and most indicated a strong desire to continue with their studies, with some reporting supportive teachers (especially female teachers) as well as support (mostly emotional) from peers. However, *pregnant girls who continued attending school after giving birth (most who said they had returned to school did so between 1 and 6 months after giving birth, and returned to the same school they were at before) also reported facing various challenges*, including being unable to concentrate; some also said they were ridiculed or made fun of by their classmates or staff. The stigma of being pregnant but unmarried and still at school led some girls to interrupt their studies:

Everybody would look at you like an animal. Avoiding you because you were pregnant ... But I didn't go to school much during my pregnancy, I only went for exams. During exams I would go with my huge tummy. They'd start speaking behind me saying no wonder [respondent's name] doesn't come to school ... They even forgot I've been having problems paying my fees. It became my pregnancy that made

me not go to school. Even my friends ... you know, you might have a friend but the moment you get pregnant you hear the parent told them they don't want them to associate with you: 'She's a bad influence because she's pregnant. She'll advise you to go after men and get pregnant too'... not knowing these things are never too far away. It can happen to either your daughter or anyone else (Adolescent mother, 19, completing high-school and owns a small business, Homa Bay).

Different factors affect whether adolescent girls continue at school, interrupt their studies or drop out after they have given birth. The girl's household situation is a key factor. *Those who continue studying after giving birth usually have good support (including financial support) from their families* and particularly their mother with childcare, and tend to be those where the household head places high value on education. Furthermore, from the parents' point of view, returning to school is not just a way for their daughter to secure a living in future, it is also a way to regain her value:

What can we do now? Because our daughters are now valueless ... we want to make them have value ... so we have to take them back to school (IGT, father, 54, house builder and pastor, Ndhiwa).

Girls who interrupt their studies typically do not have childcare support from their family, and are advised by their parents to look after their baby in the first year or two, and to return to school after that time:

We don't have the capacity to take care of the baby and feed her while she is in school so it's better she stays and breastfeeds the baby first ... and then she can go back to school (IGT, mother, 50, casual labourer, Ndhiwa).

Those who abandon their studies are typically girls from poor households whose families

struggle to pay school fees regularly, or where the girl will have to look after her child on her own and will, in some cases, also take on work. Similarly, some families re-allocate the fees that would have been used for the pregnant girl to a younger sibling who is perceived as having more opportunities to succeed. The school environment is another factor. When girls perceive they would suffer from stigma on their return, they sometimes relocate to another school. Also, some schools do not encourage adolescent mothers to return, as one key informant noted:

Sometimes implementation [of the education policy] becomes a problem especially in our schools, when you tell a principal to allow a child back, they will insist that this child will be giving a bad example to other students. But now we'll have to do that with the police because the law says they must go back to school and continue with their education (Key informant, Social Protection Officer, Homa Bay).

In the case of adolescent fathers and fathers-to-be, in most cases their studies were not affected by their girlfriend's pregnancy, although a few observed that they had skipped a few classes to accompany their pregnant girlfriend to the hospital. Only in one focus group of adolescents did one participant indicate that fathers/fathers-to-be who are themselves orphans may drop out of school so they can look for a job and support the mother of their child.

Once girls return to school, they face other challenges including (for those who returned relatively early on) the need to work out how to feed the baby (e.g. are they allowed to take breaks to breastfeed, can they afford formula milk, etc.) and if they do not breastfeed, their breasts may hurt and affect their concentration. For those who returned to school after a longer period of time, they had to repeat some classes, do their exams later than their peers and/or had fallen behind their peers (see Box 2). For all those returning, childcare remains a challenge, especially for those who do not have the support of a relative:

... [the girl's mother] agreed to take care of the baby but I think in her heart or in her head she really didn't want to. So, every time I came from school, she would just meet me with a lot of bad talk. Sometimes, I would find the baby has pooped and not been changed at all for hours. So, I just decided not to risk my baby's life and told my father that I no longer wanted to go to school (Adolescent mother, 18, sex worker, Ndhiwa).

5.1.4 Norms around marriage and cohabitation

According to respondents, the ideal age to get married varies for women and men. In the case of women, most respondents considered that the ideal age is 18 upwards, although those who are more educated would prefer to marry from their mid-twenties onwards. Men usually marry when they are older, with many respondents mentioning 20 upwards (though some also mentioned the 20–25 age range). Most respondents stated that they married for love

Box 2 Pregnancy and school

Carol is 16 years old and has a one-year-old daughter. She lives in Makongeni, in Homa Bay, with her mother and two elder brothers. She attends a Seventh-day Adventist church. Her mother is a community health volunteer.

She stopped attending school for only a month after giving birth and is currently in form 3. She says that '[she] didn't take a break because in [her] school whether you're pregnant or not you have to keep attending school. You can only be given a break for the period when you're giving birth. After giving birth you resume.' Nevertheless, she 'felt left behind because the syllabus was continuing and people were proceeding with education ... and when [she] went [her mind] was blank ... and knew nothing. So [she] felt awkward.' However, she says that the female teachers were supportive and 'would advise [her] on what to do ... show [her] the right way'.

Although her mother was angry when she first found out about the pregnancy, she is now looking after the baby while Carol is at school. Carol's 21-year-old brother is supporting the entire household financially through casual construction work. He has also taken on some household chores and stayed at home to look after the baby for a period.

The father of her child is two years older than her. They met when she was 14 and were in a relationship, but he was 'very angry' when she informed him about the pregnancy. She says: 'Because he was from a well-off family he decided to abandon me. When I informed his parents, they were so angry at me for accusing their son for something he's not capable of doing. So he decided to go and I decided to let him go.'

She did not consider having an abortion when she became pregnant because she knew of a girl who died after taking herbal remedies to induce a miscarriage.

Carol describes that several NGO programmes are implemented locally to raise awareness of SRH-related issues among adolescents (naming DREAMS, Family Option and Champion 1990). However, she observes that most organisations focus on adolescents aged 15–18, but feels they should also be targeting younger girls and boys. She herself started having sex aged 14 (not with the father of her child), which she attributes to peer pressure.

Carol claims she is now abstaining from sex. Her brother, however, says that she sometimes doesn't sleep at home and he suspects that she may actually be engaging in transactional sex for money. He claims that one of these men (an older man) slapped her because he gave her money and she 'refused to meet her end of the bargain'. He says that his mother 'quarrels and counsels her' and sometimes canes her when this happens.

(or planned to marry for love), although some were aware of cases, especially in rural areas, where parents had arranged or forced their daughter to marry to obtain the dowry. Generally, marriage ceremonies tend to be rare, with young couples starting to cohabit and the family discussing the dowry afterwards.

Reasons to get married also vary between females and males. For girls, some marriages are influenced by peer pressure, with girls wanting to emulate their married counterparts when they see them doing well and being provided for. In other cases, financial stability is a reason for girls to marry, as ‘women look for a provider who can meet their needs’, according to some men. Others noted that some girls marry because they want to avoid having more than one child out of wedlock:

One can get married because she has a kid already and fears getting another kid out of wedlock. At around 18, most of them [girls] get married. There is a girl who is barely 20 and still at her parents’ home with two kids, so most girls try to avoid that (FGD, married men aged 27–60, all with children, Homa Bay).

As discussed previously, having one child, being unmarried, and continuing to live at her parents’ house has almost become the norm for adolescent girls in these communities. However, having one child and being pregnant with another or having two children remains undesirable and not the norm. While girls with one child indicated that they were unwilling to get married because they wanted to complete their education, or they did not see any future with the father of their child, when it came to having another child there was a sense that perceptions and the situation changes, with girls feeling pressure and the need to get married. This could also be because one child can be relatively easily integrated into the parental home with the girl’s mother/grandmother taking on much of the caring responsibilities while the girl returns to school. However, with two children, there may be a sense that now the girl is behaving irresponsibly, she is expecting too much from her family and therefore needs to marry and take full responsibility. This does not mean there are

no cases where girls have more than one child and continue to be supported by and live in their parental home, and there may be cases where there are sisters in the same parental household each with one child (see Box 3); however, it does appear to be more frowned upon if a girl has two children without marrying. For adolescent boys, their traditional role as breadwinners and providers is an important factor in determining when they get married; ideally, this is when they have a job and a steady income.

Reasons that could drive some girls especially, but also boys, to marry early include poverty, and lack of support from their family, particularly those who are orphaned and/or have an early pregnancy. Less educated girls and boys also tend to marry earlier, with educational attainment being closely tied to the family’s ability to afford school fees. Some boys also stated that they married early because they performed poorly in exams, and marriage and joining the workforce was an easier alternative where they could undertake jobs that do not necessarily require professional degrees or certifications, such as being a boda boda driver. Girls who are mistreated at home, including suffering emotional or physical abuse, may also seek marriage earlier as a way to escape their home.

Girls who married at a young age are especially likely to experience violence from their spouse (who is usually older than them); according to key informants, older men want to ‘exercise their authority and girls are unexperienced’. Such girls also have few options to escape from violence, as they have usually dropped out of school, have become mothers, and have few opportunities to become financially independent. Young married couples also voiced facing financial challenges and occasionally, violence would result. As mentioned earlier, domestic violence goes unreported because it is viewed as a private problem between a husband and wife.

In terms of *change over time*, older participants voiced that nowadays boys and girls alike are marrying at older ages, driven by a preference to seek sexual activity for fun/pleasure rather than to start a family. Others also noted that many children are now conceived out of marriage, as female and male adolescents carry on with their

lives after having their first child and even start new relationships. Likewise, others mentioned that previously, girls were introduced to the parents of the boy and there was discussion of the dowry to be paid to his family. Nowadays, some youth marry against their parents' will, elope, and move away from the family homes.

In terms of *future relationships*, most female adolescents who were not yet married wanted to get married in the near future (aged 18 or before their mid-twenties). Only in a couple of instances did girls voice an interest in marrying the boy who made them pregnant. Most girls seemed disinterested in the father of the baby being

Box 3 Early pregnancy and future marriage

Mary is the 16-year-old mother of a young baby, living in Ndhiwa, with her parents and four siblings. Her 20-year-old sister also recently had a baby. Both stopped attending school shortly before giving birth. A third sister, aged 14, is still in school. They are New Apostolic Christians.

Mary's father considers it to be his wife's role to 'ensure that her daughters are not walking here and there [because] during the day when [he is] out [working], they are together.' It was his wife who observed that Mary was pregnant, although she tried to deny it at first. The father also suspects that his wife knows who the fathers of his grandchildren are, but thinks his daughters are withholding the information from him for fear that he will 'quarrel' with the boys.

Her father reported feeling 'bad [because] he had already paid the school fees and she was in school' but 'decided to just keep cool ... and take it easy' because 'in [the local] area if you make noise about pregnancy they can commit suicide or ... run away'. He and his wife would not have countenanced Mary having an abortion, as their niece recently attempted to terminate her pregnancy using herbal medicine, and nearly died as a result. Mary herself says she did not consider having an abortion, because she is 'not aware of how abortion is done'.

Mary's parents would have preferred for their daughters to complete their education before having children, but 'they do not listen ... they just listen when you speak but their decision afterwards is different ... they lack respect'. Their father attributes their pregnancies to peer pressure, saying 'Those age mates ... when they are together they are speaking about sex ... and that results in diseases and pregnancy'. He reports that his second daughter has changed since having a child: whereas before 'you could not bring her to line ... when you tell her to be calm, she could not ... [now] she speaks very softly saying, "Father I am sorry. If God helps me to remove my child I will just return to school"'. She is ashamed that her younger sister has overtaken her at school.

Mary was in form one when she left school to give birth and, on her father's advice, plans to return to school a year later when she is no longer breastfeeding the baby. Her mother will look after her child, as well as that of her sister, who will also return to school. Mary's father fears that it will be more difficult for her to marry well now that she has a child, and observes that it is usually older men who marry younger women who already have children. He hopes that by sending his daughters back to school he will increase their 'value' and they may meet a classmate who they then choose to marry. He is happy for them to marry at any age, as long as they have completed their education. He points to an example of another schoolgirl who got pregnant, whose mother came to his wife for advice. His wife advised her that the girl should return to school after having the baby, which she did; the girl went on to complete form four, study at university, get a job in Nairobi, and marry a young man her own age.

Mary's father now advises his daughters to abstain from sex. He reports that the local community health workers' children became promiscuous after accessing contraception: 'after that they were roaming dangerously ... it is just like a license for them to walk here and there ... so I always tell my daughters just to be faithful and abstain'.

their future husband because the relationship was unstable, and they perceived that the father was not looking for a serious commitment. Key informants noted that adolescent mothers are willing to marry (not necessarily the father of their child) to avoid stigma from the community (see Box 3). Our data is patchy regarding whether it is difficult for girls with children to marry, particularly to someone who is not the father of the baby. The responses indicate that this is a case-by-case basis, depending on the situation of the potential partner. Some girls noted that they may have problems marrying someone in future because the boy or man may not accept their child.

5.2 Poverty and transactional sex

Poverty, and corresponding economic necessity, is a key driver for adolescent girls to engage in transactional sex. Also, girls who belong to households where one or both parents are absent often face compounded risks that lead them to earlier sexual exposure and initiation. These girls usually lack provision of basic needs such as food, clothes and supplies (including sanitary towels) or are unable to pay school-related expenses (school materials, transport and fees). As mentioned, some girls are also put in charge of younger siblings, which leads them to become easy targets for boys or older men who offer them money, protection or gifts in exchange for sex. Sometimes, girls have multiple sponsors/boyfriends in order to meet their living needs, with each sponsor providing financial or in-kind benefit for different aspects of the girl's life, including rent, food and clothes. Some of these girls are also motivated by peer pressure from other girlfriends who have sponsors and introduce them to potential candidates:

How I started ... When we were leaving school, I would see them [her girlfriends] with men. So, this girlfriend would ask me how come I had no boyfriend of my own. She told me I needed a boyfriend. I would see how they [sponsors] could afford to buy mandazi snacks and they always had money. I decided I also wanted a boyfriend just to have money.

That's where I started and had sex with him (Adolescent girl, 19, sex worker, Homa Bay).

The age range for girls to have a sponsor varies. Some girls started in primary school (especially in the case of orphaned girls), others in secondary school or during their university years.

Some adolescent boys also engage in transactional sex with older women as sponsors, similar to the way that female adolescents have sponsors. Respondents indicated that these boys have female sponsors because they are attracted by their money but also because most young girls of their age have sponsors and the boys are left with little choice but to date older women:

Respondent 7: The boys who get 'sugar mummies' just do it for pride. Boys are proud. They want to be seen driving around in their sugar mummies' cars and be thought of as rich. Secondly they also want to be rich. They want these women's money.

Interviewer: Any other opinion on boys who have sponsors?

Respondent 3: These are boys who are lazy. The other problem is that the male sponsors have taken all young girls, leaving these boys with the older women. You find a rich man has up to 10 girls. These young boys are left with none of their age mates so they go for these women (FGD, fathers/fathers-to-be, aged 19–20, Homa Bay).

The *profile of girls' sponsors* varies widely. Some are in their teenage years, while others are reportedly 'middle age' or 'old'. Their occupations include boda boda drivers, fishermen, accountants, factory workers and teachers. *Girls come to know sponsors through various channels:* they may be introduced to them by family members (e.g. sisters-in-law); girls who travel far for school or other activities may come into contact with motorbike drivers regularly, who then become their sponsors; girls in rural areas often have to fetch water, which

brings them into contact with fishermen who become their sponsors; and at school, male teachers are also potential sponsors.

There were different views towards girls who engage in transactional sex from different kinds of respondents, including perceptions around who does transactional sex and who does sex work (see Box 4). For example, some adolescent girls indicated that they have not looked for a sponsor because they perceive that such sponsors are at high risk of being HIV positive because they have sex with many women. Other girls mentioned that they would not like to have troubles with a sponsor's wife (if they were married). However, female adolescents also indicated that girls with sponsors can usually get clothes, money and even a house in Nairobi. The views of the community are mixed. Some considered that girls who have sponsors are mainly orphaned girls in need of financial support, or those who have both parents but are poor. However, there is a perception (particularly among the older generation) that some of these girls are not necessarily poor and have material desires for items that their parents are not willing to provide (such as mobile phones, gifts or fancy clothes). The desire for such items leads 'most women to always have sponsors', according to a participant in a focus group discussion with married men. However, community members also agree that it is widely understood that girls will not marry

their sponsors, nor will sponsors seek to marry these girls.

Adolescent boys' views towards sponsors reflected feelings of peer pressure. The apparently rising sponsorship trend/norm appears to put them under financial pressure when they have relationships. Many of the boy respondents indicated that they have not been sponsors themselves but have realised when girlfriends were looking for one:

If they ask the first time, I have no issues, I'll just send. Second time, I sit them down and ask them if they're in the relationship for money or if it's genuine. That's where you see them acting all sneaky and you realise that she's not there for love, just love for money. You can't talk to them if you have no money. She can never call you, she always expects you to do all the calling (Adolescent father, 21, university student, Homa Bay).

Other male adolescents indicated that they may have been a sponsor in the past, but the relationships ended when they could no longer provide financial benefits to the girls. There is also a fine line between transactional sex and sex work, albeit with some differences (see Box 4 and section 5.3).

Box 4 Transactional sex compared to sexually-exploited children engaged in sex work

Through their accounts, our study respondents made a clear distinction between transactional sex and sexually exploited children engaged in sex work. *Transactional sex*, according to our findings, could take two main forms: (1) sex with a sponsor, who the adolescent met with on a regular basis; or (2) sex that was more sporadic and unplanned, driven by a sudden material need or by peer pressure, and the person could just be 'anyone' they might meet. Girls from rural areas whose families do not have enough money for their school expenses or girls from Homa Bay with financial needs were thought to be most at risk:

If parents can't give girls what they want, they'll decide to walk around and get it from men who can give them... (IGT, male, 21, university student and does casual work, Homa Bay)

They [parents] cannot even afford the basic requirement for adolescents, especially for the young girls, like sanitary towels ... Transport to school is another problem, that is why the boda take advantage, they carry those girls to and from school every day, and

Box 4 (cont'd) Transactional sex compared to sexually exploited children engaged in sex work

then in the process you never know what will happen ... They will even lure them with 100 shillings to go and buy the sanitary towels. (Key informant, county clinical officer and chair of adolescent technical working group, Homa Bay)

Sexually exploited children engaged in sex work, on the other hand, are considered as having a job which is usually the person's main occupation. The age range when girls start having this occupation was between 12 and 18 years. Such girls tend to be poor, lack support from relatives, some are orphans, some have young children to support and were head of the household or came from a female-headed household. One respondent shared the many reasons that led her to this occupation:

Both my parents died. We were two in our home. I remained with my sister, but she got married and her husband never liked me. So, I decided to find something to do with my future and that's when I got into this business and got a baby. Even after getting a baby he still didn't like me, so I decided to live alone. I do prostitution. (Adolescent mother, 19, sex worker, Homa Bay)

Girls are often introduced to this work by female friends who are sex workers. Respondents differentiated between different kinds of sex workers: those who work in the bar of a hotel (e.g. as waitresses) and are then 'invited' by clients to go to the rooms, while others stand outside the premises of the bar, or some enter as customers, and wait until a man approaches them.

Different kinds of encounters and work routines were described by respondents. They usually meet their clients as streetwalkers or as bar girls and the sexual encounters often take place at lodges or hotels paid for by the clients. The work is often late at night/into the early morning hours, though one respondent indicated working afternoon hours too. The usual work schedule described is over 10 hours a day, 4 days a week, though some girls said they only look for clients when they are in need – i.e. three or four times a month, when they need cash (for instance, to pay their younger siblings' school fees). Since the number of clients varies, the pay also varies – one respondent indicated earning 10,000 shillings a month, another 300 shillings per customer. The men that girls have sex with are often much older (in their thirties or older), married, and not necessarily with a regular income. Some of these clients are boda drivers and fishermen, although these are not preferred by girls due to their low incomes. Clients who have higher incomes and are of a higher socioeconomic class are more sought after and include teachers, policemen and local government staff.

Different types of risks were described related to this kind of work, including clients' refusal to pay following services, as well as threats or violence when they demand unprotected (i.e. condomless) sex:

Sometimes you're given just 200 shillings. They beat you. Some have sex with you and refuse to pay. Such are the challenges we encounter daily. (Adolescent girl, 19, sex worker, Homa Bay)

Some clients totally refuse to use protection ... They refuse because once you enter a room with them there is no negotiation ... They can beat you up. (Adolescent mother, 19, sex worker, Homa Bay)

According to respondents, authorities have little regard for their plight and that they usually do not offer them protection or refuse to assist them when they experience violence. Finally, some observed that the community do not appear to have sympathy and do not intervene if they witness violence.

5.3 Risky behaviours

In this section we explore a range of behaviours that study respondents perceived as risky for acquiring HIV or becoming pregnant. Many of these behaviours have already been alluded to, and most are not mutually exclusive, thus people could engage in one or more of the risky behaviours, which could also compound their risk of acquiring HIV and becoming pregnant. Underlying many of these behaviours, specifically in relation to HIV, is the notion that *HIV is no longer feared*. According to key informants, HIV is now seen less as a death sentence and more as a manageable disease, with increased availability of ART fuelling these notions. However, the flip side of this means that risky behaviours continue and, arguably, in some instances may increase.

Having *multiple sexual partners* and having *casual sex* were seen as risky behaviours, especially when youths do not disclose whether they have multiple partners. Although it was not common among respondents, and while both female and male adolescents could have multiple sexual partners, it appeared to be more common among boys. For boys, having multiple partners is seen as a sign of manhood and accepted; however, if girls had multiple partners (some of whom may support them financially, as discussed in the previous section), they were spoken of negatively:

Interviewer: And what do they say about a man who sleeps with different girls?

Respondent: For youths, they feel superior.

Interviewer: And what do they say about girls who sleep with different boys? Do they think she's also superior?

Respondent: They think she's bad. A bad lady, a bad girl (Adolescent father-to-be, 19, university student, Homa Bay).

Similarly, while both male and female adolescents engage in casual sex, more males reported having

casual partners than females, though again this practice did not appear to be very common among respondents. Casual sex often happens at parties, including funeral discos (see Box 5), with people also referring to the Yolo ('you only live once') phenomenon:

This is not a cultural practice but a mentality of the youth. They call it Yolo (you only live once). The youth take it to mean this as a chance of living reckless lives, partying and dating girls from every tribe, from Luo to Kalenjin (FGD, girls aged 15–19, Homa Bay).

Intergenerational sex was also seen to be a risky behaviour. As discussed earlier, young girls may have early sexual encounters with much older male adult family members, including fathers, step-fathers, uncles, brothers and cousins, and also with older boda boda drivers. Given girls' limited control and negotiating power in these kinds of encounters – where they also (according to a key informant) fear being punished if they do not do as they are told and are unable to 'say no for themselves' – adolescent girls are at risk both of acquiring HIV and getting pregnant.

These risky behaviours would perhaps be less risky if condoms were used. However, our data revealed that *condomless sex* is relatively common among youth in Homa Bay and Ndhiwa. Reasons range from very young boys not knowing how to use a condom, to girls not having enough power in relationships to demand that their boyfriends or sexual partners use a condom, to girls being given (more) money for condomless sex, to couples not wanting to use them as a sign of a faithful relationship:

Not everyone wants to use them [condoms], especially men. They have this mentality that sex is not sweet with a condom. So, you might find I started using condoms but somewhere along the line, the man makes me stop using condoms, they don't like condoms. They try to convince you by saying they aren't [HIV] positive, and you can't tell someone's status by looking at their face. So, men should be involved in

Box 5 Disco matanga: a funeral space that may lead to risky sexual behaviours

Disco matanga is defined as a ‘cultural funeral practice of the Luo in the Nyanza province ... The purpose of the disco matanga or disco funeral is to help raise money in order to give the deceased husband a proper burial ... Those who want to continue sitting on the bench have to pay 20 Kenyan Shillings, while those who don’t want to pay, get off the bench and dance. This trend continues throughout the night’ (Zolnikov, 2014: 1–2).

Respondents observed that disco funerals were a good opportunity to have sexual encounters because they usually last several days, and guests (usually relatives or community members, particularly adolescent and adult men, a few children, the inherited/widowed wife and a handful of adolescent girls) usually sleep in the house (ibid.). Other respondents shared that they find a way to leave the funeral at night and have sex with someone nearby. Other studies describe that males who request for paid dances with girls at these funerals are usually also asking to have sexual relations later on (Njue et al., 2009). However, these sexual encounters are not always carried out with the consent of girls. Furthermore, Ssewanyana et al. (2019) observe that at disco funerals, excessive substance abuse and sexual and physical violence were reported to be common, which was confirmed by some of our respondents:

Because this (the funeral disco) is done at night, you find so many people engaging in seduction and sex. And this leads to the spread of HIV and AIDS because most of the time they don’t even use condoms. (FGD, men aged 19–20, fathers or fathers-to-be, Homa Bay)

Thus, these spaces not only provide opportunities for adolescents to engage in risky sex, but they may also expose adolescent girls especially to unintentional violence and abuse when males are under the influence of drugs and alcohol.

this. They are the ones mostly against condoms. It’s so rare to find a girl who doesn’t like using condoms, it’s men (FGD, girls aged 15–19, Homa Bay).

Cultural practices were also noted to put people at risk of HIV and other STIs. For example, according to one key informant, some people (mostly in rural areas) believe that having sex with a virgin girl cures HIV. Other respondents mentioned that wife inheritance persists in rural areas, even if the husband died from AIDS or the new husband is HIV positive. Disco or matanga funerals (see Box 5) were also mentioned as a cultural practice that puts people, especially girls, at risk of STIs (including HIV) and unintended pregnancies.

Finally, men who have sex with men (MSM) and drug users also engage in high-risk behaviours. One study respondent (a male who has sex with men) reported getting tested for HIV regularly; he also mentioned that other MSM were also on PrEP. Stigma and discrimination from the family and wider

community, in the form of both emotional and sometimes physical violence, led some men to never disclose that they were MSM while others dropped out of school and moved away from the family. Some indicated that they also engage in sex work or transactional sex. These men tend to come from poor households and are also given gifts or are paid school-related expenses, according to their sponsors. They meet other men at clubs or restaurants and have sex with them at guest houses. None of them reported doing sex work as a full-time job. As in the case of female sex workers, MSM who are sex workers or engage in transactional sex are also exposed to violence when men refuse to pay them:

I have other partners. But when they want to have sex with me, they see I’m too small and they abuse me. They don’t want to pay me and become a bit violent ... I’m just given a token of appreciation (Male, 18, boda boda driver and sex worker, Homa Bay).



pressure as well being in a vulnerable situation, such as in the case of orphans, were identified as reasons why males start taking drugs:

I have no family. I had an aunt, but she also passed on ... I'm just alone because even the uncle I knew is no [longer here]. I was born this way and found myself like this. That's why I unload all my stress on drugs ... They [relatives in the village] know I use drugs, I'm not on good terms with them totally and I don't live there either (Male, 19, casual labourer, drug user, Homa Bay).

In the case of girls, one drug user interviewed indicated that she started using drugs after testing positive for HIV. Several users (both male and female) shared that using drugs is a way to combat stress. Similarly, some drug users indicated that sharing needles to save money is common, though this is clearly a high-risk activity for HIV. One user has stopped sharing though:

I used to share the needles before I got one of my own. [Supplier's name] would later bring me needles and since then I don't share. But before, we could share ... we used one needle on three people ... It's just that we didn't have an option because it also costs money (Male, 19, casual labourer, drug user, Homa Bay).

MSM who engage in sex work or transactional sex indicated not receiving proper recourse when they report violence to the police. However, one did say that he could obtain counselling from the police station when he was in need.

Respondent: In the police station we have a certain room now and a counsellor in that room, so you drop there, and you get counselled.

Interviewer: What type of counselling do they provide?

Respondent: They do not provide, they just offer so they can just challenge my brain to be a good person ... They can just pray for you (Male, 19, farmer and drug user, Ndhiwa).

Finally, *drug use*, largely of bhang (an edible mixture made from cannabis leaves and flowers, which is either drunk or smoked), since it is much cheaper than cocaine and heroin, was reported, largely among male adolescents. Peer

Other drug users observed that in some cases, some drop out of school and become *boda boda* drivers or work doing casual labour. Most drug users indicated that they remain in productive work; however, drug use can be an expensive lifestyle to maintain. While most users wished to stop using drugs, only one respondent had stopped, and one was in recovery at a rehab centre. Support from family and friends were considered as important in this process. Consumption of drugs is done privately or in small groups, and the users are largely unknown, so discrimination is generally not an issue (unlike for MSM).

6 Conclusions and recommendations

Study findings have shown that health facilities in Homa Bay (including government, NGO/FBO and private facilities) are very likely to offer SRH and HIV services, particularly in urban areas. Yet very few health facilities offer youth-friendly SRH and HIV services. The most common sources of information for adolescents about SRH and violence-related services were hospitals, health clinics, school and NGOs, but also friends, the internet, parents, relatives, the radio and, to a lesser extent, the church. Yet adolescents feel they lack adequate information on SRH and HIV for several reasons. They have little access to comprehensive sexuality education at school or at home, due to laws and policies that restrict dissemination of this information but also due to negative perceptions, religious beliefs and stigma from service providers, teachers, religious leaders, the wider community, and the family. As a result, the main message adolescents receive is to abstain from sex until marriage. Adolescents all too often remain side-lined by policy-makers, with policy and programming often inadequate to meet their SRH needs and fulfil their rights. Quite simply, adolescents need to become one of the key populations on policy-makers' agenda, particularly given current demographic and economic trends which show that almost half of the population is below the age of 15 (NCPD, 2015) and more than half (52%) of women have given birth before age 18 (KNBS, 2013). Ensuring that SRH and HIV policies are designed from a life course perspective is set to become even more pressing in the years ahead.

Furthermore, our qualitative research findings highlight that adolescents' behaviours around accessing SRH, HIV and violence-related services vary. Similarly, decisions to use these services (or not) are not straightforward. For example,

in the case of SRH, most adolescents indicated using a family planning method, particularly condoms, although they did not necessarily use them regularly and the circumstances in which they (or others) decided to use those methods (or not) also varied. Some female participants indicated having had an abortion or knowing someone who had one, while others carried on with their unintended pregnancy for fear of the consequence of abortion for their health or fertility, or because health providers refused to perform the abortion. In terms of HIV, some participants tested regularly (particularly adolescent girls and those who considered themselves at high risk), while others tested less frequently. Some adolescents also perceived that everybody is at risk of HIV due to multiple partnerships and low use of condoms. Cultural practices such as wife inheritance in rural areas and disco funerals were also perceived to put adolescents at risk of HIV and other STIs, and unintended pregnancies.

It is critical that policy-makers recognise that adolescents in Homa Bay County are engaging in sex and that they should have access to proper SRH education and awareness, including of different family planning methods, programmes and services available, in order to reduce their risk of contracting HIV and/or of unintended pregnancy. Again, current trends render this ever more urgent: our research shows that adolescents are having sex without protection and that, in some cases, adolescent girls in particular lack family planning information but also, crucially, decision-making power to persuade boys to use condoms, which puts them at risk of unintended pregnancies and HIV. At the same time, different kinds of social norms align and intersect, which in some cases result

in some adolescent pregnancies arguably being more intended than was previously thought. For example, norms around early relationships and first sexual encounters are driven by peer pressure – in the case of girls, often in the form of a perceived rite of passage to show that a girl is attractive and desired by boys, while in the case of boys, it is in the form of competitive masculinity and reflections of manhood. Condomless sex is usually seen as the norm in long-term relationships to show faithfulness to the partner. Furthermore, having one child out of marriage is accepted and has become a new social norm, particularly in a context where girls lack employment opportunities after high school and have neither the economic resources nor the motivation to continue studying higher levels of education.

Norms around becoming an adolescent mother/single mother and father are largely more detrimental for girls than boys. For example, adolescent mothers (and their families, particularly the girl's mother) become the main providers of financial support and care, while adolescent fathers may either deny the pregnancy or provide occasional financial support only. In Ndhiwa, our data indicates that girls are usually relocated to other extended family living elsewhere, due to shame and stigma of becoming an adolescent mother, while fathers-to-be usually feel relieved from the unwanted responsibilities of becoming a father when the girl leaves. Similarly, pregnant girls usually interrupt school to give birth, while fathers-to-be usually continue attending with no interruptions. While some girls are able to return to school (usually those who receive care and financial support for the child from their family), others are unable to combine being a mother and a student, so decide to drop out of school.

Poverty is another important driver of early sexual exposure and risky behaviours (e.g. multiple partnerships, drug use, transgenerational sex and casual sex, among others) that lead to (un)intended pregnancies and HIV. Adolescent girls and, to a lesser extent, boys indicated that they engaged in transactional sex with older men as sponsors because they lacked basic needs

such as food, clothes, school-related expenses, transport or even emotional protection. Most of these adolescents were also from households where one or both parents were absent, while others were escaping from violence. Although some adolescent girls and boys engaged in transactional sex occasionally, others had no option than to become sex workers.

Government policies and programmes (as well as those of the international community) should respond to these realities to address the challenges facing adolescents in Homa Bay County and to ensure that their SRH and health rights are protected and fulfilled. Such obligations are also enshrined in international declarations, conventions and commitments, to which Kenya is a signatory, including the SDGs. Hence adolescents and their particular needs, priorities and vulnerabilities need to be given special attention by policy-makers, both at county level but also beyond. Failure to do so will mean more unintended pregnancies and higher rates of HIV among the large youth population. Policies and programmes should be tailored and respond to the needs of adolescents. In practice, this will require recognition of how SRH and HIV health needs change over adolescents' life course (from early to mid- and late adolescence) and the particular challenges that adolescents face owing to poverty, but which may be further compounded by gender, disability, geographical location, marital status, and sexuality, among other factors. There is also a need to look beyond 'trends' or 'averages' to respond to the specific realities faced by different groups of adolescents who are at greater risk of engaging in risky behaviours, such as orphaned adolescents, those living in poor or female-headed households, those fleeing violent environments, those who have been physically or emotionally abused, and those diagnosed with HIV.

Therefore, we make the following recommendations to the Homa Bay County government and development partners for improving SRH and HIV programming and service provision for youth.



Young people taking a selfie during the 2018 Maisha conference at a Nairobi hotel, Kenya. © Stephen Lomlen, LVCT Health

Policy recommendations

Review messaging and information provision around SRH and HIV

Our data shows that relying on messages around abstinence until marriage rather than offering adequate information for adolescents around SRH and HIV is ineffective and counterproductive. Furthermore, adolescents indicated that they often lack information on family planning methods other than condoms and that SRH is hardly discussed at school or at home. Increasing the availability of information on SRH and HIV that adolescents can access at schools, health services, and within their households can help them to take informed decisions about sexual relationships, their chosen method of family planning, and how to protect themselves from HIV and other STIs. This can be done through the following actions:

- Review FHE policies and implementation in schools, working with teachers, headteachers and education authorities at different levels to ensure that: (1) the standard curriculum is used and where necessary adapted for different age groups (some form of tracking system could be developed with basic indicators collected on who receives FHE, for how long, what is taught, etc.); (2) teaching methods and approaches are appropriate for dealing with potentially sensitive topics; (3) potential stigma on the part of teachers is addressed; and (4) there is full consideration of who is best positioned to teach FHE and the extent to which outside teachers/healthcare/other experts should be involved.
- Disseminate information on SRH, HIV and violence-related services and programmes in schools. Information should target younger (10–14) as well as older adolescents, as it appears that younger girls were unaware of available services and support, yet there were accounts of sexual encounters at such an early age, as well as younger adolescents experiencing violence.
- Support associations and existing community-based groups (or support the formation of new ones) that focus on dissemination of information and services related to SRH, HIV and violence. Support groups by and for adolescents who are HIV positive or from the lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) community should be encouraged and promoted.

- Conduct awareness-raising with parents of adolescents, including providing information about SRH and HIV and existing programmes as well as the importance of FHE for children in schools; classes on parenting skills could be provided (also through schools or parent–teacher associations) to help parents communicate with their adolescent children on sensitive or embarrassing issues.
- Implement community-based awareness-raising programmes targeting community leaders, elders and religious leaders with information on SRH and HIV but also the need for FHE in schools; using positive role models to raise awareness can be an effective strategy.
- Balance messaging about HIV to reflect that, while ‘HIV is no longer feared’ (according to our study respondents), it is still vital to avoid risky behaviours. HIV-prevention messaging should avoid instilling fear and maintain the critical message that HIV is a manageable disease, while exploring how to ensure that risky behaviours do not increase through (for instance) noting that antiretroviral therapy (ART) may not be available for everyone all the time, that children of HIV-positive people may suffer, that while some people can live a long and fulfilled life even with HIV and on ART this may not be the case for everyone, etc.
- Design programmes that encourage positive norm change and aim to reduce stigma among different groups (parents, adolescents, peers, service providers, teachers, religious leaders and policy-makers).

Policies, programmes and financing to support adolescents

- Ensure that programming for adolescents on SRH, HIV and gender norms is included in public budgets.
- Continue supporting and financing long-term NGO programmes that address adolescents’ GBV, SRH and HIV needs.
- Raise awareness of existing policies at county level and nationally on SRH, HIV and violence-related services for adolescents. Greater awareness would allow adolescents to have more information on these topics and greater knowledge about their rights.

This would support the pathway to achieve SDG 3, particularly the achievement of universal access to SRH care services among women of reproductive age and a reduction in adolescent birth rates (target 3.7).

- Ensure that policies and local institutions offer effective recourse for adolescents who have experienced violence in the home. Several female respondents mentioned that local authorities were easy to bribe and favoured men. Others considered that the process to report violence was exhausting, complicated, and time consuming, or that constant impunity for perpetrators led them to avoid reporting it to local authorities or, indeed, to anyone.
- Review FHE policies for schools to address the limited tangible actions thus far, and find a solution to conflicting messages/policies.
- Review school health programmes on SRH and ensure that they are comprehensive, target appropriate age groups, and that teachers have sufficient skills and capacity to teach them.
- Include adolescents in the design of new policies and programmes as they are capable and eager to provide solutions according to their own needs.

Income security and livelihood opportunities

- Enact an integrated set of policies that offer income security to adolescents in vulnerable situations (e.g. orphans, adolescents living in female-headed and/or poor households, and HIV-positive adolescents). Study respondents in such vulnerable situations were more prone to engage in risky sexual behaviours from an early age and/or to look for sponsors who could reduce their economic burden and help them meet the cost of basics such as school-related expenses, sanitary pads, clothes and food. A comprehensive social protection system that guarantees access to a minimum income, from a life-course approach (ensuring that SRH and HIV programming and service provision for adolescents is included) can provide effective support for these particularly vulnerable adolescents.
- Provide income security for vulnerable girls during their school years. Girls from

poor households are more likely to engage in risky or abusive relationships or sexual encounters to meet school-related expenses (e.g. fees, materials, uniforms and transport). A tailored support package (e.g. cash-plus programmes that provide higher benefits to adolescent schoolgirls) can support and enhance their aspirations to continue studying higher levels of education.

- Implement programmes that offer adolescents a variety of livelihood opportunities (e.g. training, education and skills development). This could help them to develop new skills that they can apply in different sectors of the economy (rather than girls contemplating marriage and/or early pregnancy as their only option).
- Ensure greater financial support for adolescents in rural areas for whom it is usually more costly to attend school, and who are more likely to engage in risky behaviours such as transactional sex, condomless sex, etc.

Service delivery recommendations

SRH and HIV

- Ensure dissemination of relevant information and access to youth-friendly SRH/HIV services and programmes that are tailored to adolescents' needs. More training for staff offering such services is crucial so that adolescents are motivated to attend rather than feeling stigmatised or unwelcome. In addition to training of staff, advertising methods (posters, leaflets) designed to reach adolescents and youth, and specially designated clinic areas, could increase uptake.
- Provide family planning methods that are free and easy to access for adolescents without feeling stigmatised, as a way to increase uptake. Some respondents mentioned that they appreciated it when condoms were offered at private designated places (e.g. within toilets) or at health clinics (e.g. a condom box in easy-to-access premises).
- Offer counselling and peer support for adolescents who are facing an unintended pregnancy and adolescents from vulnerable groups (e.g. HIV-positive adolescents or adolescent MSM).

- Ensure that programmes include boys and girls; our study indicated that girls tend to be more informed about various family planning methods but that they often lack decision-making power regarding contraception. Similarly, boys feel excluded when they are not included in programmes such as DREAMS. Providing information and support for boys and girls can promote greater awareness about services and programmes and begin to tackle gender norm change.
- Improve access to post-abortion care services, reduce financial barriers, and improve the quality of post-abortion care for adolescents and youth to reduce unsafe abortion practices.
- Increase awareness of the realities and ongoing challenges (including stigma) facing adolescents who are HIV positive, sex workers or MSM. There is a need for sensitisation (in schools, health facilities and the wider community) to tackle stigma and offer the support needed by these vulnerable groups.
- Tackle stigma and prejudices around use of SRH and HIV services by adolescents through:
 - developing comprehensive communication and sensitisation approaches that address local context-specific concerns about the use of contraception;
 - training service providers on how to meet the needs of vulnerable groups within the confines of laws and policies (such as the ban on abortion and MSM) without stigmatising adolescents who need health and emotional support;
 - implementing multifaceted interventions that include gaining community-wide acceptance of adolescents' SRH and HIV needs.

Gender norms

- Implement programmes that address harmful gender norms that can lead to negative repercussions for adolescents' SRH. For example, our research identified different kinds of gender norms that lead to unsafe behaviours (e.g. norms around masculinity or faithfulness, which lead to condomless sex; norms around masculinity or femininity, which lead to multiple partnerships; and norms around femininity, which encourage early sexual relationships).

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- Target reference groups who uphold harmful norms (e.g. older adolescents with multiple partners, sponsors, those engaged in risky behaviours) as reaching these will be crucial to change gender norms and practices, particularly around unintended pregnancies.
 - Engage religious and traditional leaders such as chiefs and young men and women who are seen as leaders as key allies in promoting new norms.

Policies to support childcare

- Enact an integrated set of policies that provide financial support, affordable childcare and health services for infants and children of teenage parents. This would allow teenage mothers to engage in activities of their choice (e.g. education or work) without depending on their relatives (typically their mother) for childcare.

School-related policies

- Help reintegrate adolescent mothers into education by supporting teachers and counsellors to adopt appropriate therapy techniques that help teen mothers adjust and feel comfortable in school.
- Adopt policies for teacher–parent collaborations as one tier of an intervention model to help adolescent mothers who are struggling with social and behavioural problems at school.
- Raise awareness among school staff about the challenges facing pregnant adolescent girls or fathers-to-be, as well as adolescent mothers and fathers, so that they can explore what support the school authorities need to provide before and after a pregnant girl returns to school.

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Annex 1 Interview type and number by location

Table A1 Interview type and number by location

Interview type	Number of interviews		
	Homa Bay	Ndhiwa	Total
In-depth interviews	26	24	50
Inter-generational trios	2	2	4
Focus group discussions	4	4	8
Key informant interviews	9	3	12
Total	41	33	74

Annex 2 Details of study participants

Table A2 Gender, age, marital status and number of children of study participants

	Homa Bay	Ndhiwa	Total
Gender			
Female	22	36	58
Male	35	19	54
Age			
13–15	4	13	17
16–19	36	29	65
20–30	9	2	11
31–40	2	3	5
41–50	5	3	8
51–60	1	4	5
61–70	0	1	1
Marital status			
Single	17	22	39
Boy/girlfriend	30	17	47
Married	9	12	21
Separated	1	0	1
Widow	0	4	4
Number of children			
None	21	22	43
None but pregnant	10	4	14
1–3	17	18	35
4–6	2	1	3
7–9	2	0	2
10–12	2	0	2
Unknown	2	0	2



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