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ADOLESCENT FERTILITY IN KENYA

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PREFACE

When The Pathfinder Fund began to consider the subject of adolescent fertility in Sub-Saharan Africa some years ago, the desire to do programmes was overridden by the questions: What do we know about the situation? What descriptive information exists that defines all of this? What are the problems, if they exist, that deserve resolutions? It was then found that what does exist to describe the circumstances was literally scattered to the four winds, in a report here, an article there, a survey here, a speech there. Nothing had been done to put the information in one piece of work. That provided the raison d'etre for preparing what you will find in these pages.

This volume, and its companions, are attempts to describe what is known about adolescent fertility in four distinct Sub-Saharan African countries -- Nigeria, Kenya, Liberia and Sierra Leone. These publications are intended to be used as "resource books" or as "fact books" for programmers and policymakers, both within and outside the countries. They attempt to gather together all of the information available on the subject to date, but they do not pretend to be entirely exhaustive.

The presentation is straightforward, it describes and summarizes the health, social and demographic context in which adolescent fertility occurs in each of these countries as well as what the implications are. All of this raises a number of questions and policy considerations, each set out more specifically in the Executive Summary. This volume does not presume to resolve these questions. That is a task that is purposely left to those who will study and discuss the "facts" discussed in this text. Our hope is that Adolescent Fertility in Kenya will begin, or at least contribute to, the discussion of this important subject. If that is done our purpose in undertaking the two-and-one-half year process, more than capably done by Benjamin Gyepi-Garbrah, was well served. The challenge is to begin the look for answers to the types of questions that arise out of this series.

John M. Paxman

The Pathfinder Fund
Chestnut Hill, Massachusetts
March 1985

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INTRODUCTORY BACKGROUND

Objectives

Interest in the subject of adolescent fertility is relatively new not only in Kenya but throughout the developing and the developed countries as well. It was roughly in the early 1970s that serious thought was given worldwide to intensive and extensive studies of adolescents and their reproductive behavior. The huge increase in the number of courses, seminars, workshops, studies, newsletters, magazines and international conferences on the subject since the early 1970s attests to this. (See references in Population Reports, 1976, 1979 and 1982; World Health Organization, 1977; and Bogue, 1977.) In fact, some of the early research was undertaken in Kenya (Gachuhi, 1972, 1973, 1975).

This surge of interest grew out of the initial recognition that boys and girls, during the period of transition from childhood to adulthood, exhibit distinct physiological and psychological features which are neither characteristics of childhood nor of adulthood. Thus, adolescents constitute a separate group of individuals with their own special needs and problems (WHO, 1977). Attention to the subject of adolescent reproductive behavior was given an added fillip by findings in some parts of the world, particularly in developed countries, that the number of teenage pregnancies were increasing as were the impact of these on health. These, in turn, were sensationalized in the popular press and described, with measured concern, in some quarters as an "epidemic" of teenage pregnancies (Cutright, 1972; Parkes, et al., 1978; Hollingworth and Krutner, 1980; Smith and Mumford, 1980). In addition, early pregnancies have empirically been found to be associated with increased pregnancy complications, higher maternal and infant mortality, and lower social and occupational mobility for the young mother and child. Moreover early pregnancies are also associated with high fertility.

In many countries the interest in the various aspects of adolescent fertility is continuing. This is due mainly to the findings, reaching across many cultures and countries, that early childbearing is strongly associated with increased pregnancy complications, higher maternal and infant mortality, lower social and occupational mobility for both mother and child and with a high rate of population growth (Sai, 1975; Population Reports, M-4, 1976; Engstrom, 1978; Sai, 1978; Fortney, et al., 1979). In Africa, studies in many countries, including Nigeria, Sierra Leone, Tanzania, Zambia and Zaire, have also confirmed the hypothesis that early pregnancy is strongly associated with high rates of abortion, still births, infant and maternal mortality and morbidity, high school dropout rates among female adolescents and the attendant loss of self-esteem and confidence (Akingba, 1974; Chibungo, 1974; Paula, 1974; Arkutu, 1978; Gachuhi, 1980; Njogu; Aggarwal and Mati, 1980; Sierra Leone MOH/WHO, 1980; Stiles, 1982; Mott, 1982; Khasiani, 1985). Studies in Kenya have confirmed many of the associations described above. Concern has been expressed repeatedly in the country over the social, health and economic problems relating to early pregnancies (Ahawo, nd; Gachuhi, 1980; Njogu, 1980; Kiarie, 1981).

The objective of this paper is to describe some aspects of Kenya's adolescent fertility. In order to give a broader perspective to the subject, the paper will also describe the socioeconomic characteristics, reproductive health behavior of adolescents, as well as the demographic, social and medical implications of adolescent fertility. This will be followed, in conclusion, by a summary of the key points made in the paper. It is an attempt to collect in one document what is presently known or thought about adolescent fertility in Kenya. The presentation is derived from secondary sources of information from censuses, surveys, research, and administrative publications. No policy recommendations will be made. Rather, the hope is that these will be taken up by policymakers and population program developers in Kenya.

Definition of Adolescence

There is no universally accepted definition of adolescence. Most societies associate the biological beginning of adolescence with the time when puberty starts. But the time when adolescence ends and adult status commences is an issue of social orientation that differs widely among cultures. In many societies, social maturity or adult status is achieved when one marries. Since the age at marriage in these societies tends to be low, at least for females, the period of adolescence tends to be brief, often following fast on the beginning of puberty. This pattern is typical in the rural areas of developing countries, where the transition to adulthood is very short (Chui, 1978). The prevailing norm in industrialized societies is to extend the period of transition toward adulthood, not only through social legislation but also by increasing the amount of time taken for schooling and vocational training. There are, obviously, patterns that fall between these endpoints of the spectrum.

These biological and socially-oriented definitions fail to consider the legal aspects of the issue. Legally, the minimum age one attains the age of majority or becomes an adult varies. The law therefore

. . . attempts, to a certain degree, to take the process of individual development into account, but it also seeks uniformity and certainty and so historically has rather arbitrarily selected the magic age at which one reaches legal 'adulthood' for some or all purposes. This is commonly referred to as the age of majority. At common law, the age of majority - the age at which individuals are competent to handle their own affairs - was fixed at 21, although now, the trend is to lower that somewhat, usually at 18. Many civil law countries have followed a similar rule. So the legal definition of adulthood has tended to operate independently of other social and biological factors. This can be seen in the fact that one may be an adolescent but legally adult or a youth but legally a minor, or under-age" (Paxman, 1984).

Social scientists and medical researchers, however, have found it useful when trying to establish age limits, to take as broad a view as possible, even to the extent of distinguishing the earlier phase of

adolescence from the latter, e.g. 10-14 years, 15-19 years. It was proposed nearly two decades ago by a World Health Organization Expert Committee that the age limits of 10-20 years be used to describe, chronologically, adolescence.

The concept of youth is overlapping, consisting of late adolescence and early adulthood. Most refer to youth as the age group between 15-24, while distinguishing between early (15-19) and late (20-24) phases. "Youth" as such is also a transitional stage in human development, though it shades across the line between adolescence and adulthood.

For the purposes of this paper "adolescence" is used interchangeably with "youth" and encompasses the age group 15-24.

Adolescence in Traditional Kenya

Unlike other societies, traditional Kenyan society had a socially recognized "age set" or "age grade" system, which had its own codes of acceptable behavior, rights and responsibilities through which one could discern the concept of adolescence.

The age set institution has been a feature in almost all the major ethnic groups in Kenya. Boys and girls were initiated into the system between age 14 and 17 by means of circumcision and clitoridectomy respectively (Kaplan, 1976). Males moved through age grades from youth (those not yet initiated), warrior (junior and senior) and elder. The rights and responsibilities of members changed as one moved across the grades. The duties of the warriors, for instance, included defense, raiding, policing markets and enforcement of decisions of elders. They were expected to be "physically gallant and daring, hardy, skillful in the manly arts, willing to work hard, stoic in the face of pain, and disdainful of the comforts of home. When the age set in the senior warrior grade entered the grade for junior elder (i.e. over 30 years), its members were expected to accept marital and parental responsibilities, to forego travel and settle down" (emphasis added) (Kaplan, 1976).

Although the roles of the female age sets were not as prominent as that of the males, they had an important function in preparing them for their position in the Kenyan traditional society. The equivalent female age sets consisted of initiated unmarried women, married women without children, those with children, women past childbearing age, and the very old. Each of these groups took part in activities considered appropriate for its age.

The female age sets underscored the importance of marriage and procreation but they also gave psychological support for their members and provided their own built-in values against premarital pregnancy, which was condemned by traditional society. For instance, premarital sex was generally permitted but "unmarried girls were only allowed limited sexual play or incomplete sexual intercourse which ensured that no pregnancy would occur" (Molnos, 1973). Adolescents were taught by members of the older age set to avoid penetration and to practice

withdrawal during sexual intercourse. Among the Tuken, for instance, newly initiated girls received sexual and family life education from a woman in the generation senior to the mothers of these girls (Kattel, 1972).

Like many other traditional institutions, the Kenyan age-set system is disintegrating due to the social changes the country is experiencing. The most recent development with far reaching consequences for the female age sets is the 1982 decision by President Daniel Arap Moi to ban clitoridectomy in the country. Modern institutions, like formal education and local government, have taken over most of the functions of the age-sets. Virtual elimination of intertribal warfare and raids, together with improvements in internal security have made the military and police functions of the age-sets obsolete. Increased migration and formal sector employment are incompatible with the maintenance and organization of the system, however, sex education for adolescents has not been satisfactorily replaced.

With the continuing breakdown of the age-set system and consequent reduction in traditional support for adolescents, the latter find themselves ill-equipped to deal with some of the difficult and traumatic problems arising from Kenya's socio-economic and political transition to "modernity". The present challenge facing individual families, local agencies and the Government is to learn more about adolescents in the changing Kenyan society and to develop programs which are geared to their needs.

Country Profile

The Republic of Kenya, with an area of 582,646 sq. km., is situated in the eastern part of Africa. In 1984 it had a population of 19.4 million. This made Kenya the twenty-second largest African country in area but tenth in population size (after Nigeria, Egypt, Ethiopia, Zaire, South Africa, Morocco, Algeria, Sudan and Tanzania). Eighty-five percent of the population and almost all the country's economic activity are concentrated in the southern two-fifths of the land.

The 1979 census showed that 9.9% of the population was African and the remaining 1% consisted mainly of Asian and smaller European and Arab minorities. The country has between 70 and 80 ethnic groups. The major ones (those with over 150,000 population) are the Kikuyu, Luo, Luhya, Kalenjin group, Kamba, Meru, Embu, Kisii, Mijikenda, Turkana, Masai, Taita and Somali.

Geography

Kenya has striking climatic variations. These have exerted tremendous influence on its population distribution and economic characteristics. Much of its interior is characterized by arid and near desert conditions with less than 25.4cm (8 inches) of annual rainfall.

Cultivable land is scarce. On the basis of average annual rainfall and soil conditions, the Government classifies only 12% and 6% of the total land area as high and medium potential agricultural lands,

respectively. Only a small proportion of the remaining land is suitable for dryland farming and fairly intensive ranching, while the lack of rainfall and water resources limits the potential of approximately seventy-five percent of Kenya's land to nomadic habitation (Kaplan, 1976; United Nations Fund for Population Activities, 1979).

Economy

Kenya achieved its independence from Britain in 1963. By 1968 it had satisfactorily attained the objective set at the time of independence of revitalizing its economy and restoring the confidence of foreign investors. In 1968, the growth of its Gross Domestic Product (GDP) peaked at an impressive 7.8% per annum. This was followed by a decline in economic growth, which reached its lowest in 1975 with an increase of but 0.7%. Between 1960 and 1982 the country's GNP grew at an annual rate of 2.8%. In 1982, Kenya's per capita Gross National Product (GNP) stood at \$390 (World Bank, 1984).

The economy is mainly agricultural but the subsistence sector has been reduced to roughly one-fourth since independence. The economy still depends on just a few basic agricultural products (including coffee, tea and meat production) and invisible earnings from tourism and transportation. However, much light industry and commerce are also being developed also. Its imports consist mainly of fuels, raw materials, semi-finished products, machinery and transport equipment. Since 1974 the world oil crisis has continued to negatively affect Kenya's economy.

Population

Kenya's population has interesting features, the most striking of which is its recent growth which has been described as unique and unprecedented. Available demographic estimates in the late 1970s showed that Kenya recorded an annual population growth of about 4%, one of the highest population growth rates not only in Africa but in the world as a whole. See Annex 1 for a summary Kenya's selected demographic indices.

One noteworthy feature of Kenya's population profile is the persistent increase in its intercensal growth rate since census data became available in 1948. Between 1948 and 1960 Kenya's estimated annual population growth rate was around 3%. This reached 3.2% by 1962, increased further to 3.3% between 1962 and 1969, and by 1979 had jumped even further to about 3.8% (Republic of Kenya, 1984).

Three factors appear prominent in the steady increase in the population growth rates, namely: 1) the reduction in the death rate; 2) a slight increase in the already high birth rate in the 1970s; and 3) improvements in census taking among the population. Net migration plays a negligible part in all this. Of these factors, by far the most important is the reduction in Kenya's mortality rates through improvements in malaria eradication, increases in infant and child nutrition and higher levels of female education (Ankers and Knowles, 1977). The crude death rate (CDR) declined from 27 deaths per 1000 population in the early 1950s to 18 in 1970 and to 14 in 1977 (United

Nations, 1985, Mott, 1982). The infant mortality rate (IMR), that is, the number of infant deaths per 1000 births, also fell by more than half during the 29 year period between 1948 and 1977 -- from 184 to 87 (World Bank, 1980; Mott, 1982). By 1982 IMR had declined further to 83 (The Futures Group, 1982).

Another important factor that explains the rate of population growth is high fertility. Fertility, in contrast to world trends, actually increased further during the 1970s. Kenya's total fertility rate (TFR), which stood at 6.8 in 1962, rose to 7.6 in 1969 and now stands at around 8.0 (Kaplan, 1976; Lightbourne and Singh, 1982). These types of increases have historically been explained by the social transformations associated with the early stages of economic development (Caldwell, 1975; 3-57, 187-235). Important components in the increases in Kenyan fertility are a weakening of child-spacing customs, better nutrition and increased personal hygiene. Other factors that have influenced the trend include a lessening of sterility due to effective treatment of venereal diseases, and a fall in foetal losses, due to malaria control. All of this has combined to give Kenya one of the lowest mortality and highest fertility rates in Africa.

The effect of this increasing discrepancy between Kenya's mortality and fertility is strikingly demonstrated in its demographic projections. Projections, based on assumptions of constant fertility, prepared by Henin and Mott at Kenya's Population Studies and Research Institute, indicate that by the year 2000, Kenya's total population will have increased to 34.1 million (Henin and Mott, 1979). Official projections indicate that by the year 2000 the total population of the country will range between 35 and 38 million (Republic of Kenya, 1984). This projection differs by 4.4 million from the United Nations' medium variant figure of 38.5 million (UN, 1983). The social and economic implications associated with this growth have been well publicized and will not be discussed here. (See International Monetary Fund, 1969; Bondestam, 1972; Herz, 1974; Henin and Mott, 1979; UNFPA, 1979; Mott and Mott, 1980; S. Mott, 1980; World Bank, 1980; Mbithi and Walji, 1981.)

Internal movement of Kenya's population continues to increase, largely as a result of the marked differences in economic opportunities. Urbanization is a recent phenomenon except in the coastal area. In 1948, 17 urban centers contained but 5% of the total population. The number of urban centers, that is, localities with 2000 or more population, doubled to 34 in 1962. By 1969 the number of urban centers increased from 34 in 1962 to 48, with 9.9% of the country's population living in them. The urban population continues to increase more than the national average, due mainly to its high rate of natural increase and net gain of population through migration, amalgamation of surrounding rural localities and changes in the status of previous rural localities. Between 1969 and 1978 urban population grew by 7.7% per annum. Pressures on arable land, paucity of job opportunities in rural areas, increased possibilities of obtaining formal urban jobs and differences in living standards between rural and urban areas continue to encourage high rates of rural-urban migration. The estimated urban population of 2.4 million was equivalent to 14% of the population in

1980 and is expected to increase to about 26% of Kenya's projected population of 39 million by the year 2000. [Annex 1]

Government Policy on Population and Family Planning

Kenya became, in 1967, the first Sub-Saharan African country to adopt an official policy on population. The Ministry of Health was assigned the task of implementing this national policy, the main objectives of which were to lower the level of maternal, perinatal, infant and child mortality and to reduce family sizes through birth spacing.

However, the earliest programs were started not by the Government but by private groups. A private voluntary association in Nairobi started a family planning program with funds obtained from The Pathfinder Fund in 1952 (UNFPA, 1979). By 1957 the Nairobi association had merged with another in Mombasa to form the Family Planning Association of Kenya (FPAK), which in 1962 became the first Sub-Saharan association to be affiliated with the International Planned Parenthood Federation (IPPF). By 1967 the Government began its active involvement in population issues, after analyzing the 1962 census figures which indicated, unexpectedly, an annual growth rate of 3.2%. A Population Council advisory mission was invited to study and make recommendations on the country's population future. The mission report, submitted in 1967, was accepted by the Government and formed the basis of Kenya's population policy (Kenya Ministry of Economic Planning and Development, 1967).

The program outlined then started in earnest. By 1968 the Ministry of Health was operating 40 family planning clinics in cooperation with FPAK. By that time both Nairobi and Mombasa city governments were also sponsoring their own family planning programs.

The basic assumption underlying the Kenya program, one based on experience elsewhere, is that fertility reduction is closely associated with declines in child mortality and morbidity. The program has, since its inception in 1967, therefore, operated within the framework of maternal and child health services of the Ministry of Health. Like most such programs it is clinic-based. At these clinics, in addition to maternal and child health services, family planning advice and contraceptives are offered free of charge to adults, preferably married females aged 15-45. Emphasis is put on child-spacing rather than limitation of family size. Women with infertility problems are also assisted. The program is purely voluntary and no incentives aimed on fertility limitation are offered. Abortion services are not provided.

No specific growth rate targets were set at the national level, however, until early in the 1970s, when the 1974-78 Development Plan indicated a planned reduction of the country's 3.5% annual population growth rate to 3.3% by the end of the Plan period. The importance of the targets was also stressed in the Ministry of Health's own Five-Year National Maternal and Child Health/Family Planning Program (1975-79), which stated the Ministry's intention that the program reduce the growth rate further to 3.0% by 1980 and to 2.8% by 2000 and to lower the total

fertility rate to 4.7 by the same year. To implement this program, clinic-based family planning services were set up in 505 integrated maternal and child health/family planning clinics throughout the country, 416 run by the central government and the rest by local agencies.

Yet, after years of work in Sub-Sahara Africa, relatively few of Kenya's adult females use modern contraception. The Kenya Fertility Survey (1978) found that 42% of the country's ever-married women knew where to go for family planning services and out of these only 13% were actually using contraception.

The program achievements, or lack thereof, have been the subject of much discussion. While substantial inroads were made in the area of maternal and infant mortality, the fertility objectives have remained elusive. First, Kenyans have not altered their reproductive behavior along lines that parallel practices in other countries that have been in the throes of development. Pronatalism and desire for large families continue to be the norm. In 1978 the desired family size for adolescents aged 15-19 was 6.5, second only to Senegal's 8.8. Amongst the 29 African, Asian and Latin American countries surveyed by Lightbourne and others. Second, the resources of the program appear not to have been utilized effectively (Mott and Mott, 1980). By 1978 the program's 505 clinics were poorly distributed throughout the country. The Nairobi province, for instance, had 48 clinics serving an estimated population of 2,416 married women aged 15-49. On the other hand, the Northeastern province had four clinics each providing service to an estimated 10,000 women dispersed over an area of 32,475 square kilometers. The quality of service rendered at the clinics also varied from clinic to clinic but was generally unsatisfactory because of shortages of trained staff, inconvenient clinic hours (a third of the clinics worked part time) and lack of privacy. The program also failed to offer satisfactory service to its clients, particularly those who dropped out of the program. At the end of the plan period, therefore, effective demand for family planning services continued to be very low and large family norms still predominated. Third, though the program has had the benefit of official support, it has been cautious and the strong Government commitment and leadership, so essential for the success of any family planning program, particularly in a pronatalist culture like Kenya, were not forthcoming during the period.

The Kenyan Program has been the best funded program in Sub-Saharan Africa, having spent about \$39 million between 1974 and 1978, just under a third (US \$11 million) of which was provided by the Government and the rest by the World Bank, United States Agency for International Development (USAID), the United Nations Fund for Population Activities, the Swedish and Danish development agencies, United Nations Development Program, West German government and United Kingdom's Overseas Development Ministry (Mott and Mott, 1980; IPPF, 1980).

The planned decline in fertility has not been attained. Despite this lack of short-term success, a strong infrastructural base was laid during the period for the long term goal of the program.

The 1979-83 development plan honestly noted the negligible impact that the program has had on Kenya's fertility. It also expresses concern over the parallel problems of the very small number of active users of modern contraception and the high drop-out rate (which reaches 80%) among family planning users (Republic of Kenya, 1979). The Government, however, took an optimistic view in the 1979-83 plan and indicated that "the main emphasis of the Family Program" during the previous plan "was on building up an efficient infrastructure for the delivery of family planning services throughout the country." It acknowledged the success of that phase and indicated a change of emphasis towards program implementation. The basic objectives of the program, however, remain unchanged.

An independent assessment of the plan in 1979 by a mission on behalf of the United Nations Fund for Population Activities and in 1980 by the World Bank (two of the major donors of the NFPP) acknowledged the serious population-related problems facing the country. Moreover, they were not optimistic as to the prospective outcome of the family planning program. The UNFPA report concluded that the demographic impact of the government's health plan and its ambitious family planning program was "highly questionable." For instance, high drop out rates among family planning acceptors continued to plague the program and some plan targets, including recruitment and deployment of family planning field workers, were lagging behind schedule. It was therefore not surprising that at the end of the first quarter in 1979 only 13,319 acceptors were recruited compared with the 1978 first quarter total of 13,131, a negligible increase of 1.4% (Central Bureau of Statistics, 1979).

The most recent assessment of the program is provided in the Country Statement presented by the Government at the 1984 International Population Conference in Mexico City. The Government acknowledged that since the family planning program had not reduced Kenya's population growth rate

the programme cannot be said to have succeeded. The reasons for this failure are that the programme concentrated on the supply side of family planning services, and relied heavily on medical aspects emphasized by the Ministry of Health. Demand for creation of family planning services was almost totally ignored.

The analysis went on to review what was presently taking place in the country:

To bring about needed improvements, the Government established the National Council for Population and Development (referred hereafter as the Council) in 1982 to develop future population goals and policies and to take charge of co-ordination of all family planning services and activities undertaken both by Government ministries and non-governmental agencies. In addition to improving the delivery of family planning services, the Council is expected to undertake communication support services to increase the

knowledge in population education and demand for family planning services . . .

The Council draws together Permanent Secretaries of key Ministries, NGOs and professionals in the field of population and family planning. To guide the implementation of its decisions a Secretariat in the Office of the Vice-President is being staffed with suitable professionals. The Council's main responsibilities are formulation policies, implementation strategies and co-ordination of population oriented activities. The Council has now formulated a population policy which is being implemented by various government ministries and nongovernment organizations . . .

The weak performance of family planning programmes, e.g. the 1975 Five-Year Family Planning Programme, has prompted the Government to redefine its future plans and activities as briefly summarized below . . .

Government's major priority in future population programmes will be to reduce the rate of population growth. The first stage is to reduce the rate of growth from current rate of 318 per cent to 313 per cent by 1988. Since the Government is committed to improvement in the quality of life, which would result in further reduction of mortality, increase in life expectancy and increase in the rate of population growth fertility rates will have to be reduced to help achieve any reductions in the rate of population growth. To achieve the target of 313 per cent in 1988 the Council estimates birth rates will have to be reduced from 52 per thousand in 1984 to 44 per thousand in 1988 through recruitment of 1.5 million family planning acceptors which would result in averting about 1 million births.

An important element of the success of the above programme is encouraging Kenya's current and potential couples to accept small family sizes. Acceptance of small family norm will require an increase in formal and non-formal education and improvement in the status of women. Equal access and opportunities in higher education training and remunerative employment will be some of the tools used to help improve the status of women. In future, efforts will be made to motivate Kenyan males to adopt and practice family planning and also to provide the youth with information and education concerning population matters.

Kenya recognizes the role of alleviation of poverty and improvement of the quality of life towards the solution of population problems. Savings realized from reduced population growth would be utilized towards provision of basic needs services (including sufficient shelter, education, primary health care, potable water, food, employment and improvement in the status of women).

Research priorities to be considered in the near future will include research on determinants of fertility, mortality and infertility, reasons and causes of drop-outs from the family planning programme and best approaches to deliver family planning services. Consultancy and research services will continue to be sought from the University of Nairobi. The National Council for Population and Development will be acting as a clearing house for all demographic research.

While population education and training will continue to be offered at all levels of training of medical and paramedical personnel, the Government will also continue to train demographers locally at the Population Studies and Research Institute at the University of Nairobi, and abroad whenever this is necessary. Population and Family Life Education will be intensified in schools.

The Ministry of Health will, through the National Family Welfare Centre, intensify its programme on family planning, population education and contraceptive distribution. Some of the programme's activities will include: more use of mass media, and seminars and workshops for political leaders and administrators; expansion of contraceptive outlets through use of community-based distribution; increase of service delivery points from the current 400 to 800 by 1986; private practitioners will be equipped with contraceptives so that they can issue them free to suitable clients; and in early 1985 it is planned to make condoms and spermicides available at market places, small shops and kiosks in both rural and peri-urban areas at low cost. These strategies will increase rural outlets and make family planning services easily accessible.

The role of NGOs in providing information and education on Family Planning cannot be under emphasized indeed. There are several NGOs which are committed to assisting the Council to improving the status of the Kenyan family through information and education and efficient family planning procedures. The Family Planning Association of Kenya and the Protestant Churches Medical Association provide population education and contraceptive services; the National Christian Council of Kenya, Salvation Army and Maendeleo Ya Wanawake Organization are involved in population education and motivation; and the Kenya Catholic Secretariat and Family Life Counselling Association offer education and services on natural family planning throughout the country. Four other NGOs, the Kenya Medical Association, Kenya Girl Guides Association and Young Men's and Young Women's Christian Association have indicated their commitment to participate in the implementation of the Council's programme.

Population problem is both a national and an international problem. The Government is committed to

collaborate with local organizations, other governments and international organizations in alleviating the population problem. With this commitment in mind the Government endorses and supports the Kilimanjaro Programme of Action for African Population and Self-Reliant Development, the Lagos Plan of Action and the World Population Plan of Action. (Government of Kenya, 1984)

The rather unimpressive performance of the family planning program should be viewed against the prognosis of the population's growth and the attendant effects on the quality of life in Kenya in the next 20 years. The inevitability of increase in the population cannot be overemphasized. The basic problem is how Kenya could reduce its population growth rate to manageable levels so that the ever increasing living standards are not threatened.

At present there is evidence that unless the current family planning program is efficiently and vigorously implemented, the 4% annual growth rate may continue during the next 20 years. That will challenge even Kenya's vibrant economy. The following are key factors to be kept in mind.

1) Cultural norms associated with procreation and desirability of large families may not change particularly in the rural areas where over 80% of the population resides. Increased male-dominated rural-urban migration and the attendant increased female responsibilities for child care and for the upkeep of family farms continue to reinforce the economic and social rationale for large families in the rural areas.

2) The real status of the female is still low, although notable improvements have been made since independence. Women continue to have limited access to paid non-domestic jobs in both the rural and urban areas. The gap between the sexes with respect to occupation, education and influence is being narrowed but the pace is very slow and with increasingly limited resources it will probably take a long time before these changes have any impact on the status, role and self-esteem of the majority of the female population. In the foreseeable future, the average woman may therefore continue to view procreation as the surest way to raise her status in her community. This is supported by the finding that the desired family size in Kenya in the late 1970s was the second highest and its achieved family size was the highest among the 29 countries surveyed with data drawn from the World Fertility Survey. Kenya's preferred family size of 7.2 children contrasts with the average of 4.7 and the range of 8.9 (Senegal) to 3.2 (Republic of Korea). Its achieved family size of 8.0 was second to none (Lightborne and Singh, 1982).

3) Some non-contraceptive factors generally associated with low fertility are not important in Kenya. These include post-partum abstinence, temporary separation of the spouses, sterility and breastfeeding. The KFS found that post-partum abstinence and temporary separation of the spouses were too short to have any significant impact on fertility. Paradoxically, separations arising from long term

rural-urban migration was found to lead to higher fertility in the rural areas. Problems associated with infertility, which in the past contributed to lower fertility, have declined substantially. The only non-contraceptive factor which was found to be associated with lower fertility was the relatively long period of breastfeeding. On the average, Kenyan women breastfeed for 9 months but even this practice is falling out of fashion, particularly among the growing number of formal sector employees for whom breastfeeding is considered incompatible with their work pattern.

4) Kenya's youthful population structure, combined with its persistent high fertility and declining death rates, are very conducive to a continuing high rate of growth. The momentum generated from such a population is such that even if fertility were to fall almost immediately to replacement level the population will continue to grow for at least 40 years (The Futures Group, 1983). The proportion of Kenyan's population aged under 15 increased from 48% in 1969 to 48.3% during the 1979 census. Henin and Mott estimate that this proportion will increase further to 53.7% in the year 2000 -- all this at the expense of the older age groups (U.S. Bureau of the Census, 1978; Henin and Mott, 1979). Between the 1969 and 1979 census, the number of adolescents in the population aged 15-24 grew 72.2% in contrast with 40.1% for the total population (U.S. Bureau of the Census, 1978; Central Bureau of Statistics, 1980).

All this indicates that within the next 20 years factors associated with continuation of Kenya's high rate of population growth will probably persist. They suggest that the only alternatives available to Kenyan planners and policymakers are to improve the efficiency of its family planning programs, improve the status of women, promote other direct and indirect policies that will ultimately lead to the adoption of the small family norm, and provide the necessary services to all individuals irrespective of sex, and marital or socio-economic status to achieve this end. In this the special needs of adolescents should not be overlooked.

Family Life and Population Education

The special needs of adolescents have periodically been recognized by the Government and non-governmental agencies engaged in population activities in the country. There are, save for substantial efforts in Family Life Education, very few and inadequate family planning services geared to the needs of adolescents. In 1972 the Ministry of Health, for instance, proposed, as a long-term goal, to reduce by 25% by the year 1984 the number of pregnancies occurring in the three vulnerable groups, namely adolescents under 18, women over 35, and those with debilitating diseases (Kenya, Ministry of Health, 1972). Specific, effective, thoroughgoing, country-wide programs for the vulnerable groups have yet to be provided.

This, however, does not imply that there are no programs at all geared to the needs of special groups, like adolescents. Government and non-governmental agencies, like the FPAK and the National Christian

Council of Kenya (NCKK), provide relatively modest family planning services for adolescents. But in the main, activities have focused on giving adolescents family planning information and education.

The Government, through the Ministry of Education, sponsors, on a voluntary basis, secondary school teachers who want to undergo a course on Family Life Education given by the NCKK. The teachers, in turn, teach this course as a voluntary after-school activity (UNFPA, 1979). The course, which includes sex education and discussions on contraceptive methods, is also offered to the congregations of member churches of NCKK. The FPAK provides counselling in family planning through its Youth Guidance and Counselling Service and provides orientation courses on the subject to school teachers in the Nairobi area. In addition, the FPAK has a program which actively involves youth in family planning activities through youth clubs within the Department of Community Development (IPPF, 1981).

Adolescents in Kenya appear to have some access to information on sex education and counselling, in both formal and informal settings. The general information program of the Government indirectly reaches adolescents. The debate on total incorporation of sex, family life or population education into the school curriculum is so central to the subject of adolescent fertility that it seems appropriate to present a more detailed account of its evolution in the country.

Since the early 1970s, studies, workshops and seminars have been conducted* on the many aspects of population, sex and family life education for Kenya adolescents (Gachuhi, 1972 and 1974; NCKK, 1973; Horsley, 1976; and Igaga, 1981). Almost all the studies were directed to the school-going population and this greatly influenced the topics discussed. The discussions have touched upon most of the key issues. These included the need for the incorporation of sex and family life education in school curricula; current status of knowledge about contraceptives among adolescents; contraceptive use rates; who should teach the subject; at what level should the subject be introduced; should it be taught in schools as a separate subject or incorporated into existing subject(s) and if so with what subject should it be merged; and, lastly, the content of the subject (whether it should contain material on human reproduction, including human relationships and contraception, demographic concepts and trends, etc.).

*This whole area is subject to the vagaries of definition. Sex education is defined as "education with regard to human sexuality and reproduction, designed to help each individual to understand and control his or her sexuality." In some systems, sex education is taken to have a pejorative meaning. Family life education, has been defined by IPPF as an attempt to improve "understanding of human relationships and family roles" with a desire to enhance life "through responsible decision-making." Population education is defined as education about the causes, nature and consequences of population dynamics as related to social and economic development.

The results of the studies have generally revealed that adolescents have a low level of knowledge about the facts of human reproduction, of demographic concepts and of population trends. Horsley, for instance, found that the student population studied, scored an average of 4.3 on a maximum score of 9 on demographic concepts and trends. Both Gachuhi and Igaga found that post-elementary school students know a great deal about contraceptives but very few have actually used them. Igaga found that 40% of sexually active students do not take any precautions against pregnancy. Gachuhi also found that not all the teachers he surveyed considered themselves competent to teach sex education. Nevertheless, he thought that career teachers rather than parents should handle the subject in school, an opinion no doubt based on findings worldwide that information from family and peers is less reliable than that gained from special classes and printed materials.

The teaching of sex education to adolescents in school continues to be a controversial subject in the country although almost all the major studies, except Horsley's, do recommend it. Gachuhi found that both teachers and students in his survey wanted sex education taught to adolescents. Igaga, for instance, found that 86% of his respondents thought adolescents should be given education about sexual matters. And the reasons given for teaching the subject to adolescents, in addition to helping them make intelligent decisions about sex and population-related matters, include, among others, indirectly assisting in lowering the incidence of maternal mortality, abortions and sexually transmitted diseases (Gachuhi, 1972, 1973 and 1974; Aggarwal and Mati, 1980).

Even before these researchers joined the debate, participants in a workshop on "Utilization of Cultural Information for Population Planning in East African Schools," held in Nairobi in January 1973, had unanimously agreed that "there is urgent need to include sex education in the curricula of East African schools." In August 1973, at a seminar organized by the National Christian Council of Kenya, Headmasters and Headmistresses of Kenya secondary schools made a clear, strong case for sex education in Kenya schools. The reasoning behind their recommendation, as quoted by Gachuhi, is as follows:

- 1) When young people misunderstand sex, they not only get themselves in trouble, but also society as a whole;
- 2) Traditional systems for teaching about sex are rapidly becoming inadequate for disseminating useful information, and so far no other means for spreading this information have been devised;
- 3) While the sex urge among young people seems to be increasing, parents have abdicated their responsibility in this area and no one else is filling the gap;
- 4) Sex education should equip young people with all the necessary facts about the anatomy and physiology of reproduction as well as the emotional changes that occur in boys and girls at puberty, so that they will feel free to discuss sex with their own children, a topic which most parents shy away from today;

- 5) Sex education in the schools would protect young people from incorrect and distorted information given by ignorant people which would otherwise be misleading.

The seminar then concluded that:

Pregnancy among young people, including school children, is a real problem resulting, we feel, from society's permissiveness and perhaps from adults' abdication of their responsibilities in imparting sexual knowledge to young people . . . While V.D. and abortion are problems among many young people, we feel that teaching of sex education may or may not help in curbing the problem. However, the youth would be expected to be responsible for their actions and hopefully not involve themselves in irresponsible practices out of ignorance - the knowledge makes them aware of all the possible dangers. (Gachuhi, 1974)

It was in reaction to such recommendations and in "anticipation of increased population education activity in Kenya, particularly in the areas of teacher training and development of education materials" that Horsley was prompted to undertake her study on population studies in Kenya secondary schools under the Bureau of Educational Research, University of Nairobi. She was not satisfied with the emphasis given the individual and the family in the various studies, seminars and workshops. She wanted a broader definition of population education, one which related to the individual's environment, namely the village, community, city, province, and nation which fits the context articulated by Viederman (1974):

An education process which helps the individual 1) to learn the probable causes and consequences of population processes for himself and his communities; 2) to define for himself and his communities the nature of the problems associated with population processes; and 3) to consider the possible means by which the society as a whole and he as an individual can respond to and influence these processes in order to improve the quality of life now and in the future.

According to Horsley, "such an educational process will include many issues besides population: local, national and international economics; the changing role women play in society; and traditional versus modern culture."

Recommendations, which Horsley co-authored with Albert Maleche, then Acting Director of the Bureau of Education Research, stated that "the best approach for giving students the knowledge and skills needed to evaluate the validity of arguments and assumptions about Kenya's population policy is to offer them opportunities to plan development of their own communities and perhaps for the country as a whole." This could be done by moderating existing courses like geography, economics and general knowledge paper and others which already have development-related topics like health, nutrition, population and the

environment. Prospective teachers, particularly those majoring in geography, economics, general science, health science and biology should therefore be assisted in teaching population processes and issues. Special workshops should also be organized for practicing teachers on the same subject.

Horsley and Maleche also endorsed the NCK's "Family Life and Sex Education Syllabus for Pre-Adolescents and Adolescents" program and recommended its adoption by the Ministry of Education. They did not think, however, that population education program was necessary in the secondary/high schools for fear that such a program may stress population as one variable in the overall development complex to the exclusion of other development processes.

As the Bureau of Educational Research rightly anticipated, discussions on the need for population and sex education continued throughout the 1970s. In 1976 the Government appointed an all-Kenya National Committee on Educational Objectives and Policies (NCEOP) to "evaluate the present system of education, define a new set of educational goals for the second decade of independence and formulate a specific program of action for achieving those goals" (Republic of Kenya, 1976). The reform advocated by the Committee was a shift from an academic-oriented preparation of a small proportion of the population to a system which would prepare the majority of the population for activities essential for future improvement of the economic and social conditions in the rural areas.

Among others, the NCEOP made many specific recommendations that anticipated the goals of population education as presented by UNESCO in 1978. According to NCEOP, population education aims to enable learners to acquire the knowledge, skills, attitude and values needed to:

- Understand and evaluate the prevailing population situation, the dynamic forces which have shaped it and the effect it will have on their present and future welfare as well as that of their families, communities, societies, nations and the world;
- Make conscious and informed decisions based on their understanding and evaluations;

The NCEOP recommendations included the following that touch on population and sex education:

- 1) To make primary schools prepare boys and girls for agriculture, budgeting, family welfare and community development.
- 2) To devote the extra (two) years of the proposed nine-year basic education to the development of basic skills which are the foundation for individual effectiveness in daily life and subsequent training.
- 3) To make secondary schools train for community leadership, family life and sex education.
- 4) To require all teacher trainees to take a compulsory course on guidance and counselling as part of their training.

- 5) To require teachers to participate in guidance and counselling as part of their normal duties.

These recommendations, in addition to those submitted by other agencies, have slowly changed the government's attitude with respect to the incorporation of family life and population education in the primary and secondary school curricula. In the 1979-83 Kenya Development Plan it was stated that those recommendations of the NCEOP "which are acceptable and consistent with the strategies contained in the Development Plan have been incorporated in the Plan." However, details of the Plan did not express any strong endorsement of population or sex education within the primary or within the secondary school system. The only reference at the secondary school level pertaining indirectly to any such education was the government's measure to promote a "sense of ethical values and social obligation which will uphold the values of traditional African society while preparing for the challenges of modern society."

Population education is therefore still not part of the primary and secondary school curricula although the government continues to give indirect support to such education through its support for the introduction of NCK's Family Life Education syllabus in secondary schools as a voluntary after-school activity. This course basically deals with "preparation for adult family responsibility including matters of human sexuality, reproduction, contraception and the impact of family size on other aspects of family welfare" (UNFPA, 1979). In addition the FPAK not only provides guidance and counselling services to both out-of-school and the school-going youth it also involves the youth in family planning activities through the youth clubs of the government's Department of Community Development.

By African standards, and even compared to countries outside Africa, Kenya has a relatively progressive experience with family life and population education (Population Reports, 1982; Paxman, 1984; Stepan and Kellogg, 1974). Presently, the country's elective program of family life education, however, covers a very small proportion of the school-going adolescent population and the coverage of the out-of-school adolescents by member churches of NCK and by the FPAK-sponsored youth clubs is very inadequate.

Nevertheless, the chances of Kenya mounting its first comprehensive and nationwide population, family life or sex education program are extremely bright in the light of the excellent background work of NCK, FPAK, the University of Nairobi and the Ministry of Education. With the advent of the National Commission on Population and Development, the interest in formalizing a curriculum for family life and population has continued. The Commission has made adolescent fertility and subjects related to it one of its working priorities. A small working group, composed of representatives of the NCK and others, spear-headed by the Ministry of Education have, as of late 1984, prepared a standard curriculum for adoption into the formal school system. The penultimate step in its incorporation is to present it to the Kenya Institute of Education. By early 1985, if all goes well, the final results of what

has been a ten year process will be seen and family life and population education will be made, officially, part of the Kenya system of education.

SOCIOECONOMIC CHARACTERISTICS OF ADOLESCENTS

This section will discuss the socioeconomic characteristics of the adolescent population of Kenya. [Annex 3]

Percentage of Population

The 1969 census fixed the number of male and females aged 15-24 at 1.8 million. That was 18% of the total population. Within ten years, the adolescent population had reached 3.1 million or 20% of the total population. By 1985 the adolescent population was to reach 3.9 million.

Educational Attainment

Generally, education levels in the country have improved for all groups since the 1960s because of the post-independence Government education expansion program. Available data also show that those aged 15-24 are more educated than those over 24 and that males are generally more educated than females.

At the time of the 1969 census, only 18% and 37% of female and male adolescents aged 15-24 had ever been to school. Ten years later, as Table 1 indicates, these figures had increased dramatically to 70% for females and 85% for male adolescents. Moreover, by the time of the 1979 census, the proportion of adolescents with at least secondary school education also increased considerably. For females aged 15-19 and 20-24 those with at least secondary school education were 11% and 20%, respectively. Comparative figures for male adolescents were 23% and 36% (Central Bureau of Statistics, 1980). The 1979 census figures, however, show that although the sex differences in educational attainment continue to exist, the educational gap between them is slowly closing.

TABLE 1: Female Adolescents by Level of Educational Attainment (%) and Age, 1977-78

<u>Educational Level</u>	<u>Age Group</u>	
	<u>15-19</u>	<u>20-24</u>
No Education	17.6	30.7
1-4 Years	15.2	16.6
5-8 Years	48.7	34.1
9 ⁺ Years	18.6	18.5
Total	100.0	100.0

Source: Mott, Frank L. and Mott, Susan H.: Kenya's Record Population Growth: A Dilemma of Development, Population Bulletin, Vol. 35, No. 3 (Population Reference Bureau, Inc., Washington D.C., 1980).

Age at Marriage

Marriage is almost universal in the country, though the age at marriage is rising. There is, however, no uniform minimum age at marriage because of the many practices and regulations governing the subject. Customary and Hindu marriages accept females marrying under 16 and 16 years respectively. (According to Uche, however, a bill appended to the Report of the Commission on Marriage and Divorce recommended age 16 as the minimum marriage age for females (U.S. Bureau of the Census, 1980).

One result of the increase in educational attainment of female adolescents is a rise in the age at first marriage. Between 1962 and 1978 the singulate mean age at marriage rose from 18.4 to about 20. Marriage now tends to be delayed until the completion of one's education. This general attitude is borne out in at least one survey. At the university level, Igaga found that only 7% of his sample of Kenyatta University College students were married and 82% of the students thought age 25 was the right age for marriage. Increasing female formal education enrollment seems to have contributed to the decrease between 1969 and 1977 in the percentage of ever married adolescents aged 15-24. [Table 2] The proportion of female married teenagers fell from 34% in 1969 to 26% in 1977.

The traditional society never encouraged early marriage among males. This practice continues. The norm was for males to marry late, preferably after initiation into the junior elder age grade around age 30, to spouses much younger than themselves. This pattern is being altered a bit. In 1969, 96% of the male teenagers and 73% of males aged 20-24 were still single. Thus, although males continue to marry later than females, the present generation of male adolescents are marrying at ages somewhat younger than the traditional norm.

Marriage Type

Polygyny, the marriage type in which a man marries more than one wife, continues as an important feature in Kenya. Polygyny is also more prevalent in the rural areas and among the older and less educated population. In 1978, nearly one-third of the married women aged 15-50 were in polygynous unions. Among adolescents, however, the proportion of those in polygynous unions is lower than the national average. In 1978, 24% and 22% of the married females aged 15-19 and 20-24 respectively were married to a man with another wife.

The 1978 KFS also shows that adolescent marriages in the older age group tend to be less stable than those within the general population. Between 1969 and 1978 the proportion of adolescents aged 20-24 ever divorced increased from 4% to 5%. The latter figure was higher than the national average of 3% for those aged 15-49. During the same time frame, divorces among adolescents aged 15-19 rose only slightly, from 1.9% to 2%, well below the national average.

TABLE 2: Union Status (%) of Adolescents by Age and Sex, 1969, 1977-78

YEAR		AGE			
		Female		Male	
		15-19	20-24	15-19	20-24
1969 ^a	<u>Union Status (%)</u>				
	Single	64.1	18.6	96.3	72.5
	Married	33.7	76.2	3.4	26.3
	Divorced/Separated	1.9	4.1	0.2	1.0
	Widowed	0.3	1.1	0.1	0.2
	Total	100.0	100.0	100.0	100.0
1977/78 ^b	<u>Union Status (%)</u>				
	Single	72	21	NA	NA
	Married	26	73		
	Divorced/Separated	2	5		
	Widowed	0	1		
	Total	100	100	NA	NA
1977/78 ^b	<u>Marriage Type (%)</u>				
	Polygamous	24	22		
	Monagamous	76	78		
	Total	100	100	NA	NA

Sources: (a) Computed from United Nations: 1977 Demographic Yearbook, New York, United Nations, 1977.
 (b) Central Bureau of Statistics: Kenya Fertility Survey, 1977-78. First Report, Volume 1, World Fertility Survey, Nairobi, Central Bureau of Statistics.

Urban/Rural Residence

The size of Kenya's urban population is relatively small. In 1969 it was only 10% of the population. By 1980 an estimated 14% of the total population were residing in urban areas. [Annex 1] However, because of the tendency for adolescent males aged 20-24 to dominate Kenya's pattern of rural-urban migration, the proportion of the male population residing in urban areas continues to be far out of proportion to its size in the national population. The 1969 census and the 1977 KFS both showed that male adolescents, at least in the 20-24 age group,

outnumbered in proportions of 19% versus 13% their female counterparts in the urban areas. But now females of adolescent age are also showing a significant tendency to migrate to the urban areas. The proportion of female adolescents residing in urban areas more than doubled between 1969 and 1978. Among female adolescents aged 15-19, their proportion increased from 10% to 20%, while those aged 20-24 rose from 13% to 29% during the period. [Table 4]

TABLE 3: Urban & Rural Residence (%) of Adolescents by Age and Sex, 1969, 1977-78

YEAR		AGE			
		Female		Male	
		15-19	20-24	15-19	20-24
1969 ^a	Urban	10.0	13.0	10.3	19.6
	Rural	90.0	87.0	89.7	80.4
	Total	100.0	100.0	100.0	100.0
1977/78 ^b	Urban	20.2	29.4		
	Rural	79.8	70.6		
	Total	100.0	100.0	NA	NA

Sources: (a) Computed from United Nations: 1977 Demographic Yearbook, New York, United Nations, 1977.

(b) Computed from Central Bureau of Statistics: Kenya Fertility Survey, 1977-78, First Report, Vol. II, World Fertility Survey, Nairobi, Central Bureau of Statistics, Feb., 1980.

Economic Activity

The International Labor Organization (ILO) estimates indicate that the labor force participation rate for the female adolescent population was very low compared to that of male adolescents in both 1960 and 1970. This difference is more prominent in the 20-24 age group, where the labor force participation rate for male adolescents in 1970 and 1980 were 96% and 94% respectively. This contrasts with the female's 44% and 42% for the two years. Some of the difference can be explained by the fact that unpaid domestic activity is excluded from the definition of work.

Annex 2 also shows that between 1970 and 1980 the participation rates for both sexes in the adolescent age group range declined. This

is due mainly to the rise in the proportion of the school-going adolescent population. The trend is expected to continue and, by the year 2000, 90% of the male and 38% of the female adolescents aged 20-24 are projected to be in the labor force. Whether all of that decrease can be attributed to prolonged education remains to be seen.

The demographic characteristics of Kenyan adolescents show a general similarity to the general population, but demonstrating more marked structural change. The rate of growth of the adolescent population was higher than that of the general population. They continued to increase their proportion in the urban areas and thus have higher rates of migration from the countryside; they are becoming more educated and thus indirectly increasing their age at marriage and reducing their labor force participation rate. The latter, in turn, has increased the length of their economic dependence on their families and communities.

So they are relatively more urbanized, more educated, and profess more Christian religious affiliation. The latter has grown mainly at the expense of the traditional religions, principally due to the influence of many institutions like schools, developed by the Christian churches. [Annex 4] Because many adolescents are still in school, they also tend to have lower economic activity rates.

REPRODUCTIVE HEALTH BEHAVIOR

This section will discuss some aspects of reproductive health behavior among Kenyan adolescents. The topics that will be examined include age of menarche, fertility, maternal morbidity and mortality, abortion, contraception and sexually transmitted diseases.

Age of menarche

The average age at menarche continues to fall. It stood at 14.4 years in the late 1970s for women aged over 19 but for college students the average age is 12.9 years. (Central Bureau of Statistics, 1980; Igaga, 1981).

Fertility

Though fertility levels in Kenya are presumed to have been high for a very long time, it was only after the 1960s that information on fertility trends became available. This information reveals that the level of adolescent fertility is among the highest in Africa. (Table 4)

The fertility rate among teenagers aged 15-19 rose from 141 births per 1,000 women in 1962 to 168 in 1977, despite the decline in the proportion of married teenagers. This probably can be attributed to a combination of an increase in the incidence of out-of-wedlock births and a rise in teenage marital fertility. But the reasons behind this increase have not been carefully researched. It is true that the decline in foetal deaths and the fall in the incidence of still births arising from declines in the incidence of sterility and of malaria in the country explain part of this increase in fertility. However, it is also very probable that any increase in teenage biological capacity to reproduce due to improvement in health and general nutrition may account for a substantial part of this adolescent fertility rise. In fact, McGrath was of the opinion that the latter explains most of the increases in teenage fertility in the developing countries and that contemporary adolescents are more fecund but not necessarily any more prone to premarital sex than their forebearers. She considers sexual abstinence for earlier generations, in substantial part, a myth (McGrath, 1979). Whether these opinions match the Kenyan reality remains to be seen. There is, nevertheless, the probability that all else remaining the same, teenage fertility rates in Kenya will increase as the country's overall health and nutrition conditions continue to improve.

The older Kenyan adolescents, aged 20-24, have the highest recorded fertility level in Africa. Between 1962 and 1978 their age specific fertility rate rose further from 304 births per 1000 females to 342, an increase of 12.5% (U.S. Bureau of the Census, 1980). When combined with that of the teenage population aged 15-19 Kenya's overall adolescent fertility level may have been second to none in the whole of Africa by the end of the 1970s (U.S. Bureau of the Census, 1980).

TABLE 4: Total Fertility Rate, Adolescent Fertility Rate Per 1000 and Adolescent Contribution to Total Fertility Rate, Kenya and Selected African Countries, 1961-1982

Country	Year	Total Fertility Rate	Fertility Rate Per 1000		Contribution (%) to Total Fertility Rate 15-24
			15-19	20-24	
Kenya	1977-78	8.0	168	343	31.9
	1969	7.6	132	331	30.5
	1962	6.8	141	304	32.7
Burundi	1971	6.1	51	252	24.7
Chad	1964	5.4	171	282	42.0
Ethiopia	1968-71	5.8	163	287	39.1
Gabon ⁺	1960-61	4.1	171	190	43.5
Ghana	1979-80	6.5	136	255	30.2
Mozambique	1970	5.8	96	248	29.9
Nigeria	1981-82	5.7	127	256	33.8
Senegal	1978	7.1	197	305	35.4
Zambia	1974	6.7	137	143	21.1

Source: U.S. Bureau of the Census (1980): A Compilation of Age-Specific Fertility Rates for Developing Countries. International Research Document No. 7. Washington, D.C., Bureau of the Census.

National Population Commission: Nigeria Fertility Survey, 1981-82 Preliminary Report. Lagos; London, World Fertility Survey. 1983.

United States Bureau of the Census (1978). Kenya, Country Demographic Profiles. ISP-DP 11. Washington, D.C., Bureau of the Census. January.

Central Bureau of Statistics: Ghana Fertility Survey, 1979-80. Vol. 1. Background Methodology and Findings. Accra; London, World Fertility Survey, 1983.

Lightbourne, R. and S. Singh: The World Fertility Survey: Charting Global Childbearing, Population Bulletin, Vol. 37, No. 1. Population Reference Bureau, March 1982. Tables 3 and 5.

Very interesting differences, however, do arise with respect to adolescent fertility when analyzed by age, marriage type, education and urban/rural residence.

In 1978 only 8% of the female population remained single by age 25. It is not surprising then that many of the births should occur to the female age group 20-24. This age group contributed to 21% of all fertility in 1978, while those in the age group 15-19 accounted for 11%. This is, incidentally, the norm in almost all developing countries. In the developed countries most births occur at a later date and most often in the 25-29 age group.

Unlike the total female population, in which women in monogamous unions tended to have a higher fertility rate than their counterparts in polygynous unions, the 1973 Demographic Baseline Survey showed that adolescents did not provide a clear cut pattern. [Annex 2] While the average 15-19 year old in polygynous marriages recorded a higher rate of fertility than those in monogamous marriages, the older adolescents (20-24) followed the pattern of the general population with a higher fertility rate among those in monogamous marriages.

Education has been found to be one of the main channels of socioeconomic change which negatively effects fertility behavior. According to Carleton, education influences fertility patterns through:

- i) giving access to information about family planning methods;
- ii) developing the capacity for efficient use of family planning methods;
- iii) giving orientation of motivation with respect to family size; and
- iv) intensifying the motivation with respect to family size (Carleton, 1975).

In conditions, as in Kenya, where very few people actually use modern contraceptive methods, the influence of education would at first glance seem to be restricted almost exclusively to delays in marriage, thus reducing the female reproductive years.

The KFS did not find a clear cut relationship between education and fertility for all age groups. The older population, aged over 24, with primary education tended to have the highest fertility rate even when age at marriage and the proportion married are held constant (UNECA, 1979). For the adolescent population the results were different. As Table 5 indicates, adolescents with more education tended to have lower fertility than those with less education. In 1978 adolescents with no education had an average 1.5 children compared with 0.6 for those with 9 or more years of formal education. This distinct difference among adolescents is explained by their age at marriage and proportion married because when the fertility levels among them were controlled with respect to these two variables the observed differences entirely disappeared (UNECA, 1979). Thus, even if the use of education in the strategy of Kenya's family planning program could be questioned with respect to the older population, it remains an effective tool for the younger and relatively more educated adolescent population.

TABLE 5: Age Specific Fertility Rates (per woman)
for Female Adolescents by Age, Marriage Type,
Education and Residence. Kenya, 1973-78

Variable	Year	Age		
		15-19	20-24	15-24
<u>Marriage Type</u>	1973 ^a			
Monogamous		0.275	0.400	
Polygamous		0.38	0.341	
<u>Education</u> ^k	1977/78 ^b			
None				1.5
1-4 years				1.1
5-8 years				0.9
9 ⁺ years				0.6
<u>Residence</u>	1973 ^c			
Urban		0.078	0.264	
Rural		0.125	0.353	

Sources: (a), (c) Central Bureau of Statistics: Demographic Baseline Survey Report, 1973 DSU/Kenya, Laboratories for Population Statistics, Reprint Series No. 17, Chapel Hill, N.C., The University of North Carolina at Chapel Hill, May 1976.

(b) Mott, Frank L. and Mott, Susan H.: Kenya's Record Population Growth: A Dilemma of Development, Population Bulletin, Vol. 35, No. 3 (Population Reference Bureau, Inc., Washington, D.C., 1980).

* Data refers to average number of children born by women aged 15-24.

Most researchers would agree that certain aspects of urbanization like housing shortages, higher rents, prolonged female education, increased individualism, and breakdown of pronatalist cultural norms act as an incentive for the acceptance of small family norms (ECA, 1979). The KFS found convincing evidence of the depressing influence of urbanization on fertility to confirm this general finding. And unlike the effects of education this was found among both the adolescent and the older adult population.

Adolescents in urban areas recorded a lower fertility rate than adolescents who resided in rural areas. As Table 5 indicates, the rural fertility rates for the teenagers and older adolescents in 1978 were 62% and 75% respectively higher than the urban rates. This is very

consistent with findings in other surveys concerning urban-rural fertility differentials (UNECA, 1979). Because of the small size of Kenya's urban population, however, many researchers do not consider increasing urbanization as one of the important short-term factor in Kenya's population program.

Maternal Mortality and Morbidity

Again, we do not have accurate countrywide data for Kenya on pregnancy-related mortality and morbidity. However, studies across cultures in almost all parts of the world reveal that complications associated with early (below age 20) and late (beyond age 34) childbirth are worse than those occurring in the 20-34 age group. And in a developing country, like Kenya, where medical conditions are already inadequate the problems get aggravated. This is confirmed by available information from surveys, hospitals and clinics. Maternal mortality in the late 1970s in the developed countries was around 0.2 per 1,000 births compared with Kenya's 3.5 deaths per 1000 births during the same period. In an editorial in the East Africa Medical Journal, Prof. J.K.G. Mati observed that less is known about the extent of Kenya's maternal morbidity but "the large number of patients in hospitals and on waiting lists for repair of vesicovaginal and retrovaginal fistulae are a living testimony of the magnitude of the problem" (Mati, 1980). Studies conducted at the country's largest referral hospital, the Kenyatta National Hospital, indicate that maternal mortality among adolescents is extremely high, far higher than among those aged 25 years and over. Makokha's study of maternal deaths occurring to females ages 15 to 36 in this hospital between 1972 and 1977 showed that adolescents, aged 15-20, accounted for fully one-third (32%) of deaths among women aged 15-36 (Makakha, 1980).

Contraception

Contraceptive use rates in the country are very low. For all evermarried females towards whom the resources of the family planning programs have been and continue to be directed, only 12.6 were found in 1978 to be using what are thought to be efficient contraceptive methods, i.e., the pill, IUD, injection, female or male sterilization, condom or other modern female methods. Only 4.7% and 9.9% of equivalent ever married adolescents aged under 20 and 20-24, respectively, were found to be using contraceptives. For the overall adolescent population, irrespective of marital status, the respective proportions using modern contraception in 1977 were 3.4% among the under 20s and 10.8% for the 20-24 age groups (Table 7). The average of 11.1% for all females aged 15-50.

The pill and condom continue to be the most popular modern contraceptives among adolescents. The sheer number of adolescents was such that between 1974 and 1978 married adolescent contraceptive acceptors used a substantial part of the contraceptive services of the country's family planning program (Nortman and Fisher, 1982). In 1978 adolescent acceptors, mostly from the 20-24 age group, constituted 42% of the 61,100 acceptors, compared with 44% of the 40,600 acceptors in 1974.

TABLE 6: Contraceptive Use Rate (%) Among Female Adolescents by Age. Kenya, 1977-78

<u>Type of Contraception</u>	<u>Under 20</u>	<u>20-24</u>
None	83.1	69.4
Pill	1.5	7.1
IUD	0.4	1.8
Douche	1.0	1.6
Condom	1.7	3.9
Rhythm	8.9	15.4
Others	3.4	0.8

Source: Central Bureau of Statistics: Kenya Fertility Survey, 1977-78. First Report, Volume 2, Central Bureau of Statistics; London, World Fertility Survey, 1980. Table 4.3.1C.

In spite of the general low contraceptive use rates, the KFS found that awareness of the means to prevent pregnancy among the population in general is quite high. This is not surprising considering the emphasis over the years on information and education. For females aged 15-50, 84.4% had heard of modern contraception. Among females under 20 years 72.9% had heard of at least one modern contraceptive method. The equivalent figure for those aged 20-24 was 87.8%. The wide discrepancy between awareness and use of contraception among the female population continues to confound observers and will challenge the ingenuity of population program managers for some years to come.

Pregnancy Termination

Comprehensive nationwide information on abortion practice does not exist. From data obtained from hospitals and clinics, the general impression, sometimes anecdotal, among physicians is that the incidence of abortion, especially illegally induced, is high. According to Aggarwal and Mati, the incidence of abortion "has attained the proportion of a serious public health problem" (Aggarwal and Mati, 1980). Their study of 1,424 abortion cases admitted at Kenyatta National Hospital between January 1 and June 30, 1978 also indicates that the incidence of abortion among adolescents is particularly high. Abortions were more prevalent among adolescents, out of all proportion to their numbers in the study population. They also signaled more severe consequences for adolescents. Adolescents, aged 15-24, were responsible for 84% of all the septic cases; and those aged 14-20 accounted for 53.1% of all the septic abortions. [Annex 2] Most of these septic abortions arise from the unhygienic environment in which the procedure is performed, usually by ill-trained abortionists. Nearly two-fifths of all non-septic abortions occurred among adolescents aged between 14 and 25. (Their proportion in the general population aged 15-45 in 1979 was 50%.)

Sexually Transmitted Diseases

Data on sexually transmitted diseases (STD) in general are difficult to come by, but their close association with respect to pelvic sepsis, infertility in women, blindness in newborns and their high treatment costs are well known (Perine, et al., 1980). Kenya clinic statistics, however, indicate that thanks to the use of penicillin and other anti-biotics the incidence of STD (particularly gonorrhea) in the general population has declined considerably (Gachuhi, 1973; Perine, et al., 1980). The reduction in STDs is believed to account partially for the increase in Kenya's fertility rate during the 1970's since the decline in the incidence of venereal diseases helped in reducing further the rate of infertility in the general population. It is also believed that a decline in STDs was experienced by the adolescent population. But no good data are available to substantiate this.

Recently, Perine and others identified the insensitivity of certain STDs to the commonly used antibiotics in the country. This poses a serious threat to the containment of these diseases particularly among adolescents who are becoming more sexually active at younger ages.

IMPLICATIONS OF ADOLESCENT FERTILITY

The importance of marriage in the Kenyan culture cannot be overemphasized. In almost all the ethnic groups it is mainly through marriage that the adolescent female gains the social recognition of an adult and becomes a responsible member of the community. The status is enhanced when the marriage produces children. The gap between age of marriage and of first childbirth among adolescents is usually very small. This incidently is sustained by social pressure from the extended family members for early postmarital childbirth, while other adolescents are forced to legitimize their premarital pregnancies with marriage. Early childbirth affects the social and health conditions of the mother, child, and the overall community, as well as the growth rate of the population. This section will discuss these issues.

Medical and Health Implications

Mortality and morbidity rates among adolescents are generally lower than that during any other phase of life (the lowest rates are for the 4 - 14 year old age group) (WHO, 1977). However, for females, pregnancy-related mortality and morbidity constitute an important aspect of their overall health condition. The health risks associated with pregnancy are very high for adolescents under age 20. This declines in age group 20-30 and rises again after age 30-35. This pattern generally holds true throughout the world although poor nutrition, lack of antenatal care and inadequate health education can certainly aggravate the situation.

Pregnancy-related risks affect not only the teenage mothers but their children as well (Population Reports, 1976; 1984). Pregnancy-related complications for young mothers include first and third trimester bleeding, severe anemia, prolonged, difficult and obstructed labor, cephalopelvic disproportion, preeclampsia and eclampsia, and high tendency for surgical delivery. For the children, low birth weight, prematurity, stillbirths and high perinatal mortality are common. Available data indicate that Kenya does not deviate very much from the general pattern.

Ngoka and Mati evaluated all 567 patients under age 20 who delivered for the first time at Kenyatta National Hospital in 1978. Births to that age group comprised 11% of the 5127 deliveries at the hospital that year. They found the existence of increased perinatal mortality and premature rupture of membranes; they also confirmed the presence of preterm delivery and low birth weight, both of which were associated with poor antenatal care and poor education levels among the adolescent mothers. On the other hand, they did not find the adolescents registering high incidence of preeclampsia, high maternal mortality nor high operative deliveries, as is the case in other parts of the world. Rather, vaginal delivery among the adolescents was higher than in the rest of the obstetric population and, surprisingly, the rate of adolescent maternal mortality was lower (Ngoka and Mati, 1980). Njogu's case study of 16 girls, all of who were expelled from secondary school because of pregnancy, also showed that none of the girls had

delivery complications, no one had a cesarean delivery, all the babies were normal though mostly under weight (Njogu, 1980).

The results of these Kenya studies are then similar in some ways to those done elsewhere in the world, different in others. But much is yet unknown about the situation in Kenya. Data on the incidence or intensity of pregnancy-related complications indicate that they are generally higher in the developing countries because of poverty, ignorance and lack of efficient and comprehensive prenatal and postnatal care. The respective obstetrical and pediatric complications for the adolescent mother and child in the developing countries therefore tend to be more life threatening. Some of the conditions of this stereotype may not apply to Kenya, though where increases in health care coverage and in education levels have been substantial in the past decade and a half.

The Kenya studies and the studies in other parts of the world confirm the general conclusion that age is the most important factor associated with the incidence of adolescent pregnancy-related mortality and morbidity complications. However, the results of Ngoka and Mati's study and that of Njogu concerning the lower maternal mortality, higher vaginal deliveries and the unimportance of pre-eclampsia among adolescents do lend further credibility to the works of Deschamps in France, Bremberg in Sweden and of Efiog and Banjoko in Nigeria that there may be other very important factors associated with these complications (Deschamps and Valantin, 1978; Efiog and Banjoko, 1975). Deschamps found that adolescents, having their first births, who enrolled in special teenage pregnancy programs have no greater obstetrical or neonatal risks than adult women (Deschamps, 1976). Bremberg's study of Swedish teenagers also showed that with good living conditions and overall accessibility of prenatal care, complications among adolescents are not any more frequent than among other women having their first births (Bremberg, 1977). Efiog and Banjoko also found that in Nigeria increased incidence of pre-eclampsia and low birth weight, among adolescent mothers, diminished considerably with good antenatal care.

These results indicate that when proper antenatal care is made accessible to adolescents, irrespective of socioeconomic background, most of the serious complications associated with adolescent pregnancy can be reduced substantially. Unfortunately, maternal and child health programs in the country do not appear to cater to their needs. The emotional and other psycho-social problems that the pregnant teenager faces, particularly those who are unwed, are invariably ignored. In addition, for whatever the reasons, most of the very young pregnant adolescents hesitate to seek obstetrical care. And this is aggravated in cases involving unmarried adolescents who have to contend with social disapproval. Njogu, for instance, found that of the 16 girls she studied, 15 did not attend antenatal clinic while in school. Six of them failed to attend even a single antenatal clinic during their pregnancies. The 10 girls who attended clinics did so only after they were at least five months pregnant. Though the girls did not experience any discrimination in the clinic, they "felt unsure in the clinic partly because the clinic personnel treated them just as they treated their

older clients" assuming that they had come with similar expectations and experiences. All this seems to support the need to establish special clinics, or at least special approaches, for pregnant adolescents and to include material on the sensitivities and other psycho-social needs of pregnant teenage adolescents in the training or refresher courses or workshops of physicians, midwives, and other health providers.

Data on abortion is scarce, but the little that is available shows that abortion among adolescents is increasing. A 1978 study of abortion cases at Kenyatta National Hospital found that adolescents were responsible for most of the abortion admissions and that they also represented 84% of all the septic cases (Aggarwal and Mati, 1980). And such cases, compared to non-septic abortions, require the most hospitalization and use of health facilities. (A 1983 multi-center study in Zaire, for instance, found that induced abortion patients, on average, required 4.1 days of hospitalization compared with 2.3 days for patients admitted with spontaneous abortions.) Illegal abortion is also one of the major causes of death among adolescents.

Abortion and its complications, therefore, contribute to loss of human life and over-utilizes Kenya's health services and facilities out of all proportion to the total number of hospital admissions.

Demographic and Social Impact

The age at which women begin to have children has a very close relationship to the overall growth of population in a community. Because most births take place within marriage, studies across cultures indicate that early age at marriage tends to lead to higher fertility and population growth. This for two reasons: 1) the earlier childbearing begins, the greater the number of fertile years to be spent and the greater the likelihood of higher total fertility, and 2) short spans between generations accelerates growth rates. One of the very important reasons responsible for the decline in fertility in the European countries in the late 19th century, during their demographic transition to low fertility and low mortality levels, was the increase in marriage age (Hajnal, 1965). Any increase in the average age at marriage, as is happening in Kenya, and, more important, any increase in the average age at first birth inside or outside marriage should, in theory, have a negative impact on the growth rate of that population.

The social and economic consequences of early marriage and childbirth on the mother and child are substantial. They are aggravated if the young mother is unmarried and the child is born out of wedlock. Early pregnancy and childbirth restrict the future opportunities for social and economic advancement. The combination of the two invariably put either a temporary or permanent stop to education and career opportunities. Schools do not generally cater to the needs of pregnant students. Students who become pregnant in Kenya are faced with two difficult choices: either abort their pregnancies before they are detected in order to continue their education, or drop out voluntarily in order to have the child. For some their hand is forced. They are simply dismissed from school.

A small proportion of the adolescents in Kenya who leave school may be lucky enough to receive moral and material support, of one kind or another from their parents. Some of these are the parents who discreetly take their daughters from school and after delivery, arrange to have them return to school, while they take care of the upkeep of their grandchildren. There are other adolescents in the country who, through the effort of their parents, are admitted to maternity homes during their sixth month of pregnancy. Unfortunately, Kenya has very few such homes. At these homes both the mother and child are looked after. Roughly six weeks after delivery, the mother and baby are discharged or the child is put up for adoption (Kiarie, 1981). The remaining unlucky majority, from predominantly low income households, invariably drop out of school permanently to deliver their babies either out of wedlock, or within a marriage undertaken in haste.

Hastily arranged marriages have a tendency to help reduce some of the social stigma and psychological problems arising from the ridicule that the young unwed adolescent mother may encounter; but this type of marriage may not be able to effectively contain the socioeconomic problems associated with the failure to see schooling through to its conclusion.

In a very recent study of teenage pregnancy and childbearing in Nairobi, it was found that

although adolescent expectant and nursing mothers would like to reintegrate back into the main stream of society through education training or employment, numerous cultural and structural constraints relegate them into situations of marginality, apathy, high fertility and subsequent poverty (Khasiani, 1985).

In their worldwide review of legal rights of children, Lee and Paxman found that, generally, the gap between the rights of legitimate and illegitimate children is closing (Lee and Paxman, 1974). There is no information that the contrary is the position in Kenya at present. However, within the poor urban communities, the importance and the influence of the extended family, which used to provide for the needs of all children, irrespective of legitimacy status, is gradually declining. Children born out of wedlock to adolescents in these communities are increasingly the subjects of neglect and even abandonment. When some of these girls discover that they have been, in the words of Kiarie, "cheated" and "have in fact become pregnant they become so bitter that it takes weeks and months of reassurance by social workers for them to learn to trust a man again. Some of them do not even want to look at their baby when it is born" particularly in cases of 'taboo babies,' that is when the father is a relative (Kiarie, 1981).

CONCLUSION: SUMMARY OF KEY POINTS

This study is basically an overview of some aspects of the adolescent fertility in Kenya but with emphasis on the socio economic, fertility and pregnancy-related conditions of female adolescents. The main sources of data utilized were from secondary sources. These included censuses, other official publications, surveys and research reports. On the basis of what has been presented here, the following summarizing points occur:

Socioeconomic Characteristics of Adolescents

- 1) The youth population aged 15-24 is growing faster than the general population. In 1969, there were 1.8 million adolescent males, and females, in Kenya, 17.8% of the total population. At the time of the 1979 census, this figure had risen to 3.1 million or 20.0%. By 1985, the adolescent population is projected to reach 3.9 million.
- 2) The adolescent population is more educated than the adult population aged 25 years and over.
- 3) Adolescents professed more to Christian faith than the rest of the population.
- 4) Adolescents tended to live in urban areas. Compared with only 9.9% of Kenya's population residing in urban areas in 1969 the equivalent figure for male and females aged 20-24 were 20% and 13%. And in 1977 the female figure had risen to 29%.
- 5) Generally, because of increased schooling among adolescents their labor force participation rates are low and falling compared to those of the adult population. Male adolescents continue to have economic activity rates twice as high as the females.
- 6) Polygyny continues to be an important aspect of Kenya's culture. In 1977, 24% and 22% of married female adolescents aged 15-19 and 20-24 respectively were married to husbands with more than one wife.
- 7) The adolescent population is gradually marrying at later ages. The potential for further increase in their average age at marriage exists because of increases in school attendance rates. There is a tendency to discourage marriage during the period when schooling is being acquired.
- 8) Adolescent marriages tend to be less stable than those within the older general population.

Family Planning Services, Sex Education and Counselling

- 1) The country has had an official policy on population and a family planning program since 1967. But access to family planning information and counseling for adolescents is very inadequate, although various groups in the country have been working in the area.

2) Programs on sex education and counselling, under the title of family life education, are presently provided by the member churches of NCKK, FPAK-sponsored youth clubs of the Department of Community Development and some secondary schools. These are generally undertaken on a voluntary basis.

3) The majority of students and teachers surveyed over the years think family planning education should be provided for adolescents. The need for sex education has also been endorsed by the NCKK and heads of the secondary schools.

4) Discussions on the incorporation of family life education, with a sex education component into the official curriculum continues. The out-of-school population seems to be left completely out of efforts to convey these concepts and information.

Reproductive Health Behavior

1) The present generation of adolescents are having children at slightly older ages than earlier generations. Almost all of these births are occurring within marriage. In 1977 only 6.9% of the population aged 20-24 years had their first birth when they were less than 15 years old compared with 9%, 11% and 12% for those aged 25-29, 30-34, and 35-39 years respectively.

2) Adolescents are generally healthier than the general population. Pregnancy-related complications, especially among the very young, are worse than those of the adult population. This statement, however, refers particularly to those aged 15-19 who were found to have the highest abortion rates. While some differences exist in the delivery-related complications between adolescent and older women, Kenyan adolescents appear to suffer less complications than their counterparts in other developing countries.

3) Adolescents were generally aware of contraception, but very few use them. The KFS found that 73% aged 15-19 and 88% aged 20-24 have heard of at least one method but less than 8% had ever used contraception.

4) The most popular methods of contraception among adolescents are the pill and condom. Abortion is practiced among adolescents, but there is a split of opinion over whether it is acceptable. Forty percent of Igaga's respondents were opposed to it. The larger society condemns it.

5) Adolescent fertility rates are high. They have continued to increase since 1962. The age specific fertility rate of 342 per thousand women aged 20-24 recorded in 1977 is one of the highest, if not the highest, in Africa.

6) Education appears to affect adolescent fertility significantly. The average number of children ever born by women aged 15-24 and with 9 or more years of education was 0.6 compared with 1.5 for those without any education.

7) Urbanization among adolescents also decreases fertility. The age specific fertility rate per woman for those aged 20-24 and residing in urban area was 0.264 compared with 0.353 for those residing in rural areas in 1973.

Implications of Adolescent Fertility

1) The rising but still very low average age at marriage among females contributes substantially to sustain the high fertility rate in Kenya. This, combined with declining mortality, lies behind the country's acceleration in population growth since the 1960s.

2) Pregnancy among young adolescents is one of the principal causes of the rise in school drop outs from elementary through universities and loss of confidence and self-esteem among those affected.

3) Induced abortion is considered a serious public health problem in Kenya. Its incidence and associated complications are high among adolescents, who accounted for the majority of abortion cases admitted at Kenyatta National Hospital in 1978.

4) Complications associated with early childbirth among young adolescents in the country include increased perinatal mortality and premature rupture of membranes; presence of preterm delivery and low birth weight which are also associated with poor antenatal care and poor education among adolescents. These have serious public health implications because these complications raise the general level of maternal morbidity and mortality. In addition they tie down available health resources.

5) Most of the very young pregnant adolescents, particularly the unmarried, hesitate in seeking obstetrical care, a practice which tends to negatively affect the treatment outcome of associated complications.

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ANNEX

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ANNEX 1: DEMOGRAPHIC INDICATORS, KENYA, 1950-2000

Medium Variant	1950	1960	1970	1975	1980	1985	1990	1995	2000
<u>Population by Sex</u>									
1 Total (In 000's)	5822	7903	11290	13703	16766	20600	25413	31374	38534
2 Male (In 000's)	2852	3901	5601	6807	8337	10252	12657	15637	19219
3 Female (In 000's)	2970	4002	5689	6896	8492	10348	12756	15737	19315
<u>Age Indicators</u>									
4 Median Age	15.5	15.1	14.6	14.4	14.2	14.1	14.0	14.1	14.3
5 Dependency: Age 0-14 .	102.7	104.1	108.7	111.5	113.6	115.0	115.4	114.6	112.1
6 Dependency: Age 65+ .	6.5	5.5	4.5	4.3	4.1	4.0	3.9	3.9	3.9
7 Dependency: Total	109.2	109.6	113.2	115.8	117.7	119.0	119.3	118.5	116.0
<u>Specific Age Groups</u>									
8 Adolescents/Youth:									
15-24 (In 000's)	1052	1532	2127	2545	3145	3889	4845	6067	7552
9 Women:									
15-49 (In 000's)	1208	1678	2382	2858	3468	4239	5224	6477	8048
10 Women: 15-19/15-49(%) .	24.0	25.0	24.3	24.8	25.3	25.6	26.1	26.2	26.1
11 Women: 20-24/15-49(%) .	19.5	20.3	20.5	19.8	20.0	20.3	20.4	20.7	20.8
12 Percent Urban (%)	5.6	7.4	10.2	12.0	14.2	16.7	19.5	22.7	26.2
13 Pop. Density (/SQ.KM.)	10	14	19	24	29	35	44	54	66
Median Variant	1950-55	'60-65	'65-70	'70-75	'75-80	'80-85	'85-90	'90-95	'95-2000
<u>Average Annual Change</u>									
14 Pop. Increase									
(In 1,000's)	182	300	377	483	613	767	963	1192	1432
15 Births (In 1,000's) ..	351	495	587	708	855	1029	1247	1502	1765
16 Deaths (In 1,000's) ..	169	194	210	226	243	262	284	309	333

ANNEX 1 (Continued)

Median Variant	1950-55	'60-65	'65-70	'70-75	'75-80	'80-85	'85-90	'90-95	'95-2000
<u>Rate of Annual Change</u>									
17 Pop. Change Total(%) .	2.90	3.48	3.66	3.87	4.03	4.12	4.20	4.21	4.11
18 Urban (%)	5.7	6.6	7.0	7.2	7.3	7.4	7.4	7.2	7.0
19 Rural (%)	2.7	3.2	3.3	3.5	3.5	3.5	3.5	3.4	3.2
20 Crude Birth Rate (In 1,000's)	55.9	57.1	56.7	56.7	56.1	55.1	54.2	52.9	50.5
21 Crude Death Rate (In 000's)	26.9	22.5	20.3	18.1	15.9	14.0	12.4	10.9	9.5
<u>Fertility & Mortality</u>									
22 Total Fertility Rate	8.20	8.15	8.10	8.19	8.22	8.12	8.00	7.75	7.31
23 Infant Mortality Rate	163	130	118	106	92	82	72	64	56
24 Life Expectancy: Male	37.1	41.4	43.8	46.3	48.9	51.2	53.5	55.7	57.8
25 Life Expectancy: Female	40.2	44.6	47.0	49.6	52.3	54.7	57.1	59.4	61.5
26 Life Expectancy: Total	38.6	43.0	45.4	47.9	50.5	52.9	55.3	57.5	59.6

Source: United Nations: Demographic Indicators of Countries. Estimates and Projections as Assessed in 1982. New York: United Nations, 1985.

ANNEX 2 - KENYA: General Demographic Background for Males and Females
aged 15 - 24

YEAR	Measure or Item	Female		Male	
		15-19	20-24	15-19	20-24
1977/78 ^a	<u>Age specific Fert Rate</u> (per 1000 women)	168.0	342.0		
1969 ^b	<u>Union Status %:</u> Total	100.0	100.0	100.0	100.0
	Single	64.1	18.6	96.3	72.5
	Married	33.7	76.2	3.4	26.3
	Divorced/Separated	1.9	4.1	0.2	1.0
	Widowed	0.3	1.1	0.1	0.2
1977/78 ^a	<u>Union Status %:</u> Total	100	100	NA	NA
	Single	72	21		
	Married	26	73		
	Divorced/Separated	2	5		
	Widowed	0	1		
1977/78 ^a	<u>Marriage Type %:</u> Total	100	100	NA	NA
	Polygymous	24	22		
	Monagamous	76	78		
1969 ^c	<u>Education %:</u>	<u>15-24</u>		<u>15-24</u>	
	Primary	16.2		31.4	
	Secondary	1.8		4.9	
	Higher	0.3		0.6	
1977/78 ^d	<u>Education %:</u> Total	100.0	100.0	NA	NA
	No Education	17.6	30.7		
	1-4 Years	15.2	16.6		
	5-8 Years	48.7	34.1		
	9+ Years	18.6	18.5		
	TOTAL	100.0	100.0		
1977/78 ^a	<u>Religion %:</u> Total	100.0	100.0		
	Catholic	37.2	39.1		
	Protestant	56.6	52.2		
	Moslem	3.5	5.1		
	None	0.2	0.3		
	Other/NS	2.6	3.4		
1969 ^b	<u>Urban/Rural Residence %:</u>				
	Total	100.0	100.0	100.0	100.0
	Urban	10.0	13.0	10.3	19.6
	Rural	90.0	87.0	89.7	80.4

Annex 2 (cont.)

YEAR	Measure or Item	Female		Male	
		15-19	20-24	15-19	20-24
1977/78 ^e	<u>Urban/Rural Residence %:</u>				
	Total	100.0	100.0	NA	NA
	Urban	20.2	29.4		
	Rural	79.8	70.6		
1960 ^f	<u>Labor Force Participation Rate %</u>	42.0	46.0	83.73	97.7
1970 ^f	<u>Labor Force Participation Rate %</u>	40.15	44.22	78.96	95.82
1968/76 ^d	<u>Infant Mortality Rate</u>	106.9	108.7		
1972-77 ^g	<u>Age Distribution of Maternal Deaths % (at Kenyatta Nat'l Hospital)</u>	26.3	25.3		
1978 ^h	<u>Percent Distribution of Abortions (at Kenyatta Nat'l Hospital)</u>				
	Non Septic	34.8	36.8		
	Septic	53.1	51.3		
1977/78 ^a	<u>Contraceptive Use Rates %</u>				
	Total	100.0	100.0	*First age group refers to under 20 years	
	None	83.1	69.4		
	Pill	1.5	7.1		
	IUD	0.4	1.8		
	Douch	1.0	1.6		
	Condom	1.7	3.9		
	Rhythm	8.9	15.4		
Others	3.4	0.8			

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- Sources: (a) Central Bureau of Statistics: Kenya Fertility Survey, 1977-78. First Report, Volume 1, World Fertility Survey, Nairobi, Central Bureau of Statistics.
- (b) Computed from United Nations: 1977 Demographic Yearbook, New York, United Nations, 1977.

Annex 2 (cont.)

- (c) U.S. Bureau of the Census: Kenya - Country Demographic Profile, Washington, D.C., Bureau of the Census, January, 1978.
- (d) Mott, Frank L. and Susan Mott, 1980 op cit.
- (e) Computed from Central Bureau of Statistics: Kenya Fertility Survey, 1977/78, First Report, Vol II, World Fertility Survey, Nairobi, Central Bureau of Statistics, Feb., 1980.
- (f) International Labor Organization: Labor Force Estimates and Projections, 1950-2000. Vol II, Africa, Geneva, International Labour Office, 2nd Ed., 1977.
- (g) Makokha, A.E.: Maternal Mortality-Kenyatta National Hospital, 1972-77 in East African Medical Journal, Vol 57, July 1980, pg. 451-460.
- (h) Aggarwal, V.P. and Mati, J.K.G.: Review of Abortions at Kenyatta National Hospital, Nairobi, in East African Medical Journal, Vol. 5, No. 2, Feb. 1980, pg. 138-143.

ANNEX 3 - KENYA: Age Specific Fertility Rates (per woman) for Females
15-24 by Marriage Type, Education and Residence

<u>YEAR</u>	<u>Variable</u>	<u>Age</u>		<u>Remarks</u>
		<u>15-19</u>	<u>20-24</u>	
1973 ^a	<u>Marriage Type</u>			
	Monogamous	0.275	0.400	
	Polygamous	0.38	0.341	
1977/78 ^b	<u>Education</u>			Data refers to <u>average number of children born by women aged 15-24.</u>
	None		1.5	
	1-4 years		1.1	
	5-8 years		0.9	
	9+ years		0.6	
1973 ^c	<u>Residence</u>			
	Urban	0.078	0.264	
	Rural	0.125	0.353	

Sources: (a) and (c) Central Bureau of Statistics: Demographic Baseline Survey Report, 1973 DSU/Kenya, Laboratories for Population Statistics, Reprint Series No. 17, Chapel Hill, NC, The University of North Carolina at Chapel Hill, May 1976.

(b) Mott, Frank L. and Mott, Susan H.: Kenya's Record Population Growth: A Dilemma of Development, Population Bulletin, Vol. 35, No. 3 (Population Reference Bureau, Inc. Washington DC, 1980).

ANNEX 4: KENYA: Socio-economic Characteristics of Female Adolescents by Age, Education, Residence, Religion and Contraceptive Use

<u>YEAR</u>	<u>Variable</u>	<u>Ever Married</u>		<u>Never Married</u>	
		<u>15-19</u>	<u>20-24</u>	<u>15-19</u>	<u>20-24</u>
1977/78	<u>Education</u>				
	None	39.1	35.6		
	1-4 years	16.0	18.4		
	5-8 years	37.4	34.2		
	Secondary+	7.4	11.7		
	TOTAL	100.0	100.0		
1977/78	<u>Residence</u>				
	Urban	16	18	22	64
	Rural	84	82	78	36
	TOTAL	100	100	100	100
1977/78	<u>Religion</u>				
	Catholic	37	38	37	42
	Protestant	49	51	59	55
	Moslem	9	6	2	2
	None/Others/NS	5	4	2	1
	TOTAL	100	100	100	100
1977/78	Modern Contraceptive Use (%):	<u>Ever Married</u>		<u>All Women</u>	
		<u>Under 20</u>	<u>20-24</u>	<u>Under 20</u>	<u>20-24</u>
Total		100.0	100.0	100.0	100.0
Use		4.7	9.9	3.4	10.8
Non-use		95.3	90.1	96.6	89.2

Sources: Extracted from Central Bureau of Statistics: Kenya Fertility Survey, 1977/78 First Report Vol. ii, World Fertility Survey, Nairobi, Central Bureau of Statistics. February, 1980.

ANNEX 5: KENYA: Age at First Birth by Socio-Economic Status

<u>VARIABLE AGE AT FIRST BIRTH (%)</u>								
<u>Education</u>	<u>15</u>	<u>15-17</u>	<u>18-19</u>	<u>20-21</u>	<u>22-24</u>	<u>25-29</u>	<u>30+</u>	<u>No. Births</u>
None	11.8	29.4	19.9	12.6	9.9	5.3	1.7	9.4
1-4 years	7.2	30.7	20.7	12.2	7.6	2.6	0.1	18.4
5-8 years	3.8	22.6	19.0	12.5	4.1	0.9	0.2	36.9
Secondary+	2.0	10.6	14.0	12.1	6.7	1.5	0.2	52.8
<u>Pattern of Work (Ever-married women only):</u>								
Before & Now	7.6	12.9	24.9	23.1	19.3	5.3	0.6	6.3
Now not Before	6.8	28.5	19.3	17.0	14.4	4.1	0.8	8.9
Before & After	5.9	17.5	28.9	22.5	9.5	2.5	0.6	2.7
Only After	12.0	35.8	21.5	16.0	9.1	1.6	1.0	3.0
Only Before	8.2	26.5	27.1	18.6	8.2	3.6	0.4	7.4
Never Worked	9.8	32.3	22.4	13.9	8.9	4.3	1.4	6.9
<u>Residence</u>								
Rural	7.8	26.0	19.3	12.8	7.6	3.4	1.1	22.1
Urban	7.5	25.6	18.6	9.8	7.4	2.3	0.4	28.4
<u>Religion</u>								
Catholic	7.6	26.1	19.2	11.7	7.9	3.8	0.8	22.9
Protestant	7.0	25.4	19.4	13.2	7.1	2.4	0.8	24.6
Muslim	12.3	29.8	18.8	9.1	6.2	3.9	2.3	17.7
Other	10.2	36.4	13.1	8.8	17.0	4.0	0.0	10.5
None/NS	11.9	26.4	17.9	12.2	10.2	6.8	2.8	11.8
<u>Current Age:</u>								
Under 20	3.6	16.3	6.2	0	0	0	0	73.9
20-24	6.9	30.7	25.4	13.8	4.0	0	0	19.1
25-29	9.2	29.2	27.0	16.1	10.1	3.0	0	5.4
30-34	11.1	31.2	24.4	18.4	7.7	3.8	0.2	3.3
35-39	12.2	28.8	21.3	14.0	14.3	5.6	2.2	1.6
40-44	8.1	29.6	16.6	17.7	13.5	7.9	3.1	3.5
45-49	6.4	20.7	18.5	19.7	14.9	11.8	5.3	2.8
50	11.0	23.2	7.8	22.0	22.6	3.9	6.1	3.4

Source: Extracted from Central Bureau of Statistics: Kenya Fertility Survey, 1977/78, First Report Vol. II, World Fertility Survey, Nairobi, Central Bureau of Statistics, February 1980.

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ADOLESCENT FERTILITY IN KENYA: HEALTH AND SOCIAL IMPLICATIONS

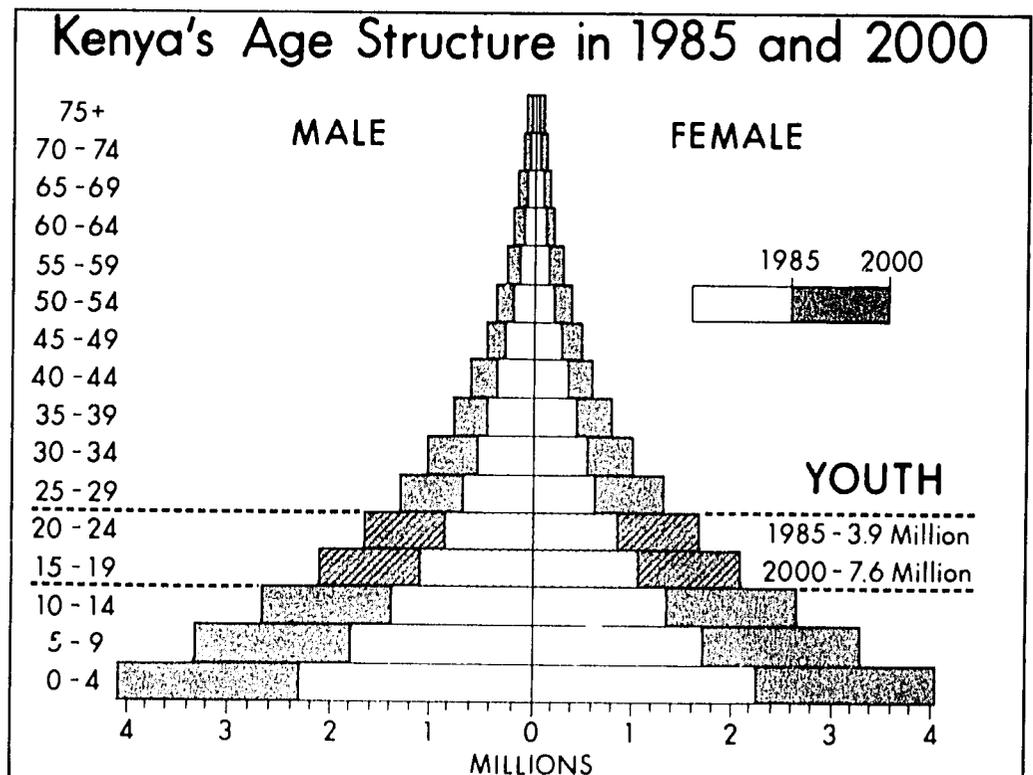
Adolescence is a critical period of biological and psychological change. For the nearly 4 million youths between the ages of 15 and 24 in Kenya, the biological change is liable to coincide with social transitions and stresses. One result of the rapid growth in the number of adolescents in Kenya is that young persons are becoming an increasingly important segment of the sexually active population. Yet their needs regarding information, health care and family planning are often overlooked, principally because of how Kenyan society views its youth.

This Executive Summary will survey findings in four areas that affect the long-term welfare of individual adolescents as well as Kenyan society as a whole:

- *The health risks to both mother and child when adolescent pregnancy occurs.*
- *The suspected high incidence of sexually transmitted diseases (STDs) among youth, particularly in urban areas.*
- *The absence of adequate sex and family life education programs, now that modernization is causing a decline in traditional teaching and guidance in these areas.*
- *The social and economic disadvantages inflicted on young women when they have an unwanted pregnancy, leading to an increase in illegal abortions, rising school drop-out rates and other long-term adjustment problems.*

Demographic Profile of Youth

- *Youth aged 15-24 make up about 20 percent of Kenya's population.*
- *The latest census reported 3.1 million persons aged 15-24 in 1979. The United Nations projects an increase to 3.9 million in 1985.*
- *The 15-24 age group is the fastest growing segment of the population. It will almost double in size, to 7.6 million, in the next 15 years.*

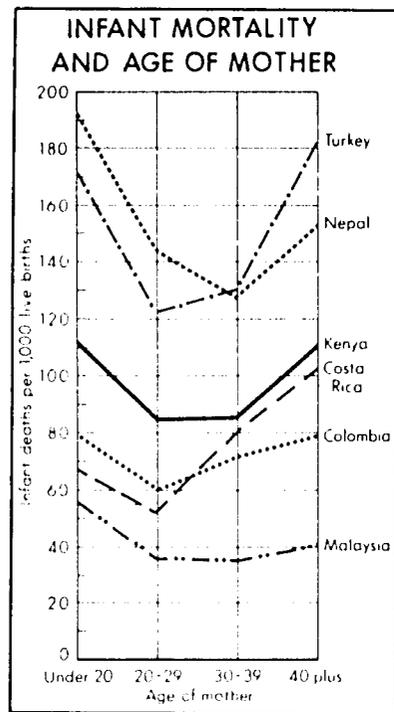


Source: United Nations, 1982 Assessment.

Health Risks of Early Pregnancy

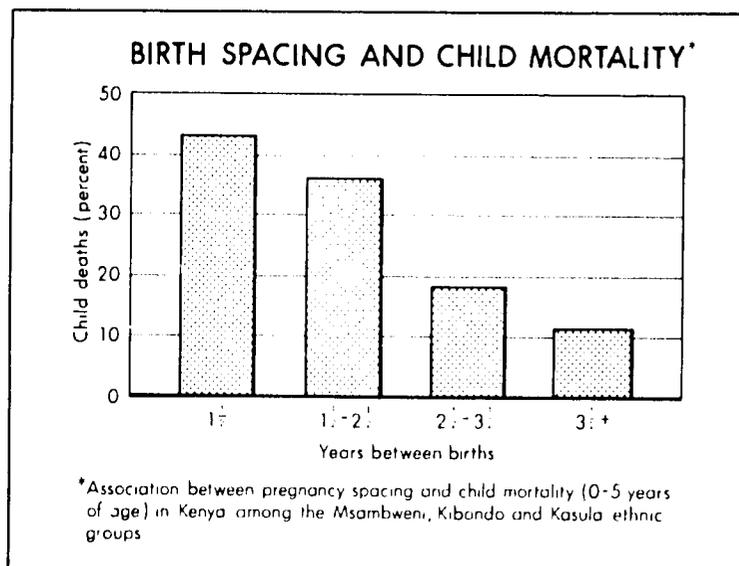
- *Pregnancy among teenagers seems to be rising. The fertility rate among 15 to 19 year-olds in Kenya rose from 141 births per 1,000 women in the early 1960s to '68 in the late 1970s, despite a decline in the proportion of married teenagers.*
- *At the same time, the average age of menarche has been falling so that girls are reaching sexual maturity on average by the age of 13.*
- *By 20 years of age, the majority of Kenyan women have had at least one child.*
- *The risk of pregnancy-related death and sickness is very high for adolescents and their children. Studies in Kenya show that high death rates, premature delivery and low infant birth weight are associated with poor health care and lack of education among adolescents.*

Pregnancies to women under 18 are considered a high risk. Maternity-related complications are among the leading causes of death for women aged 15-24 in Africa, especially in the younger ages. Because of their ignorance or immaturity most young adolescents (particularly the unmarried) delay or forego medical care before their babies are born, a practice which tends to heighten the chance of complications. Although many of the medical problems of adolescents are due to inadequate care both before and immediately after the baby is born, other factors relating directly to the mother's young age increase the medical risks for adolescent mothers whose bodies have not yet reached full maturity. Studies in Kenya show that maternal mortality among youth is far higher than among those aged 25 years and over.



Source: Population Information Program, Johns Hopkins University, 1984.

Early pregnancies pose special health risks for the child as well as for the mother. Anemia and other pregnancy disorders in young women not only increase maternal mortality, they also cause low birth weight and increase the chance of infant death. The risk is compounded if the young mother continues to have more children. A study of three tribes in Kenya shows that when there is only a short interval between the birth of two children, the survival and health of both the younger and older child are placed at increased risk.



Source: Centers for Disease Control (CDC), 1983.

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POLICY CONSIDERATIONS AND QUESTIONS

Sex and Family Life Education

Although traditional beliefs still persist, they are no longer as effective as they used to be in providing guidelines for the prevention of unwanted pregnancy during adolescence.

QUESTION: SHOULD PROGRAMS OFFERING SEX AND FAMILY LIFE EDUCATION AND INFORMATION BE EXPANDED TO REACH ALL ADOLESCENTS, BOTH IN AND OUT OF SCHOOL?

Family Planning Services

Family planning practice can contribute to the health of young men and women, yet family planning services for adolescents are inadequate in Kenya. Although Kenya has had an official family planning program since 1967, and the explicit goal of reducing the number of high risk pregnancies among adolescents under age 18 since 1972, both government and private clinics offer very few services geared to the special needs of youth. Services for men and unmarried women are particularly lacking.

QUESTION: SHOULD CLINICS AND OTHER CONTRACEPTIVE PROVIDERS INSTITUTE SPECIAL PROGRAMS TO REACH CERTAIN GROUPS OF SEXUALLY ACTIVE ADOLESCENTS, SUCH AS STUDENTS OR YOUNG MARRIEDS?

Provision of Contraceptives

Adolescents, married and unmarried alike, are generally aware of contraceptive methods but very few use them. Only 4 percent of married women under age 20 and 7 percent aged 20-24 use contraception.

QUESTION: SHOULD CONTRACEPTIVES BE MADE MORE ACCESSIBLE TO ADOLESCENTS?

Preventing Illegal Abortions

Making contraceptives easily available to sexually active adolescents who want to control their fertility offers them a choice other than illegal abortion.

QUESTION: SHOULD FAMILY PLANNING OUTREACH PROGRAMS BE INITIATED IN AREAS WHERE THE INCIDENCE OF ILLEGAL ABORTION IS HIGH?

Stopping the Spread of STDs

Many contraceptives (such as condoms and spermicides) provide mechanical and chemical barriers to the spread of sexually transmitted diseases.

QUESTION: SHOULD THE PUBLIC HEALTH CAMPAIGN AGAINST STDs INCLUDE CONTRACEPTIVE ADVICE AND SERVICES?

Lowering School Drop-Out Rates

Early, unintended pregnancy among schoolgirls is a major reason for dropping out of school. As a result, opportunities that otherwise would have been available are foreclosed for the teenaged mother. There are many negative social, health and economic consequences of this pattern.

QUESTION: SHOULD PREGNANT STUDENTS AND TEENAGED MOTHERS BE ENCOURAGED TO CONTINUE THEIR EDUCATIONS?

Although girls are nearly as likely as boys to enter primary school, they are much more likely to drop out along the way. In 1979 only 41 percent of enrollments in the first four years of secondary school were female. Girls have not made as much progress as boys in the higher grades because there are far fewer openings available, the quality of the average girls secondary school is below that for boys and the variety of available classes is narrower.

The more education a woman has, the later she tends to postpone motherhood. Secondary school women start having their families three and a half years later than women with less than five years of schooling.

QUESTION: SHOULD EDUCATIONAL OPPORTUNITIES FOR GIRLS BE EXPANDED?

MEDIAN AGE FOR FIRST BIRTH AMONG WOMEN CURRENTLY AGED 20 TO 24			
Level of Education			
None	1-4 years	5-8 years	9+ years
17.7	17.7	18.3	21.2

Source: Kenya Fertility Survey, 1977-78.

Delaying Teenage Marriage

Women are seldom admitted to government vocational schools and they comprise only about a quarter of university enrollments. Their labor force participation is half that of men. Instead of gaining equality, the trend is toward a continued drop in women's labor force participation, making the gap between the number of women and men in the workforce even larger.

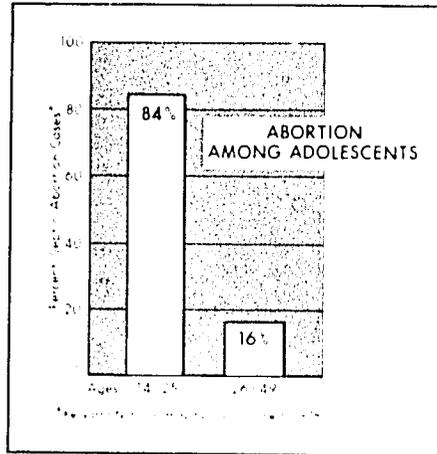
QUESTION: SHOULD WOMEN BE GIVEN MORE TRAINING TO IMPROVE THEIR EARNING CAPACITY AND PROVIDE THEM WITH EMPLOYMENT OPPORTUNITIES AS A WAY OF DELAYING MARRIAGE AND CHILDBEARING?

MARRIAGE AND FERTILITY RATES						
Country	Year	ALL MARRIED WOMEN		WOMEN AGED 15-19		
		Total Fertility Rate (TFR)	Mean Age at Marriage	Fertility Rate Per 1,000	Contribution (%) to TFR	Percent Ever-Married
Kenya	1977-78	8	18	168	11	28
Lesotho	1977	6	18	102	9	32
Nigeria	1980-81	6	17	127	11	44
Ghana	1979-80	7	19	136	11	31
Liberia	1970-74	7	-	231	17	41
Sierra Leone	1970s	6	16	212	19	72
Senegal	1978	7	16	197	14	59

Source: Benjamin Gyepi-Garbrah, Pathfinder Fund, 1984.

Preventing Abortions

- Adolescents are generally healthier than the total adult population but their pregnancy-related conditions are worse. This is particularly true of women aged 15-19 who have the highest abortion rates of all women.



Source: Aggarwal and Mati, 1980.

- Early, unwanted pregnancies among adolescent women contribute substantially to the incidence of illegally induced abortion.
- Complications associated with illegally induced abortions have serious public health implications because they raise the level of maternal morbidity and mortality. In addition they divert limited health resources.

Abortion is a major public health problem in Kenya. Although little documentation exists, data obtained from hospitals and clinics as well as the general impression among doctors indicate that the incidence of illegally induced abortion is high, particularly among adolescents. While young women aged 14 to 25 make up about half of the female population of childbearing age, one study showed that they accounted for 84 percent of all septic abortion cases admitted for treatment at Kenyatta National Hospital in Nairobi.

Sexually Transmitted Diseases (STDs)

- Sexually transmitted diseases (STDs) are a leading cause of miscarriage, infertility among both men and women, and blindness in newborns.
- While the incidence of sexually transmitted diseases seems to have declined in the general population, the insensitivity of certain STDs to antibiotics poses a serious threat to their containment, especially among young people who have very high rates of these diseases.

The sexual behavior of adolescents is changing in many African countries such as Kenya; many say the trend is toward more and earlier sexual activity. It is believed, and confirmed by the little data that are available, that the incidence of sexually transmitted disease is high among teenagers in many areas.

Part of the reason for these high STD rates is the influence of urbanization. Migration to urban areas is especially common among youth as they seek either educational or employment opportunities. Male youths in particular comprise a disproportionately large segment of the urban population. But young women also are drawn to the cities in great numbers. By 1979 almost 30 percent of Kenyan women aged 20-24 resided in urban areas, compared to only 14 percent of the total population. In cities the presence of recently arrived, unmarried migrants and the disruption of traditional family units contribute to sexual activity and hence to the incidence of STDs. In Nairobi, an estimated 7 percent of the population has gonorrhea, which is becoming increasingly resistant to penicillin, the antibiotic used most often as treatment.

Sex and Family Life Education

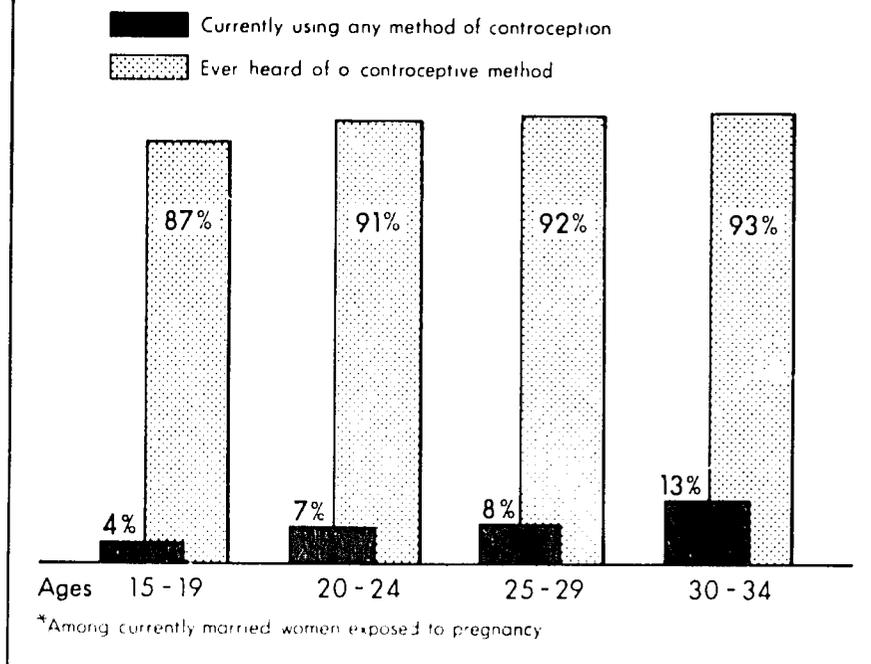
- Kenya's adolescents have very limited access to programs offering sex education and counselling.
- Traditional systems for teaching about sex and reproduction are rapidly becoming inadequate for disseminating useful information, and so far no other thoroughgoing means of educating and informing adolescents has been devised.

In years past, traditional society provided informal sex education and offered support which helped guide Kenyan adolescents away from premarital pregnancy and births spaced too closely together. Young women were taught methods of preventing unwanted pregnancy by their elders. However, with the breakdown of the traditional system, young persons now are left without adequate

knowledge and guidance about how to cope with their own rapidly changing sexuality. Studies tend to confirm that Kenyan youth have a low level of knowledge about human reproduction.

The majority of students and teachers think family planning education should be provided for adolescents. The need for sex education has also been endorsed by the National Christian Council and heads of the secondary schools. Yet, so far, only a few secondary schools have begun to offer family life education. This voluntary program covers only a small proportion of school-going adolescents. The opportunities for out-of-school youth to attend such classes are even more limited, although some classes are offered through the National Christian Council and the Family Planning Association.

CONTRACEPTIVE KNOWLEDGE AND USE IN KENYA*



Source: Kenya Fertility Survey, 1977-78.

Social and Economic Consequences of Early Pregnancy

- *Of all married women in Kenya, one-fifth have given birth before their first marriage.*
- *Early pregnancy is one of the principal causes of rising drop-out rates among students in elementary school through university.*
- *The social and economic disadvantages of early childbirth for both mother and child are enormous; and they are aggravated if the young mother is unmarried.*

Early pregnancy and childbirth restrict future opportunities for social and economic advancement. Schools presently have no programs to accommodate the needs of pregnant students. Indeed, the usual practice, if the student does not withdraw voluntarily, is to expel her. The desire to remain in school leads many students to procure an (illegal) abortion before their pregnancies are detected in order to continue their educations. Few adolescents who leave school are fortunate enough to receive moral and material support from their parents, to allow them to return to school. There are very few maternity homes in Kenya where pregnant teenagers may receive the care they merit.

Many pregnant students drop out of school permanently to deliver their babies, sometimes out of wedlock, and to enter premature marriages. Children born out of wedlock suffer because the young mother is severely limited in her ability to improve the family's living conditions. The children often are the victims of neglect and abandonment. Early marriage tends to reduce some of the social and psychological problems arising from the disapproval and discrimination which the young unwed mother may encounter; but this type of marriage is often unable to offset the socio-economic problems that result from leaving school. Also, such marriages may be unstable; divorce and separation rates among the 20-24 age group are higher than among older couples.

The problems that accompany unwanted pregnancies are especially acute for the poor. The very poor and very young mother is likely to be severely overburdened, especially when she is unwed and the child unwanted. When children suffer from malnutrition, infections, parasites and lack of learning, their physical and intellectual development will probably be retarded in adolescence. Adolescent pregnancy increases the risk that this pattern will be repeated in the next generation, thus establishing or reinforcing the cycle of deprivation.

Additional copies of this Executive Summary and the study upon which it is based, *Adolescent Fertility in Kenya*, by Benjamin Gyepi-Garbrah, may be obtained from The Pathfinder Fund, 1330 Boylston Street, Chestnut Hill (Boston), Massachusetts 02167, U.S.A. or The Pathfinder Fund Africa Regional Office, P.O. Box 48147, Nairobi, Kenya.