

**SOCIO-CULTURAL DRIVERS OF ADOLESCENT PREGNANCIES AMONG  
SCHOOL GOING GIRLS IN KITUI TOWNSHIP SUB-LOCATION, KITUI  
COUNTY, KENYA**

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**A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of  
Master of Arts in Gender and Development Studies of South Eastern Kenya  
University.**

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**DECLARATION**

I understand that plagiarism is an offense and I, therefore, declare that this thesis is my original work and has not been presented to any other institutions for an award.

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## **DEDICATION**

This thesis is dedicated to my beloved family members.

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## **ABBREVIATIONS AND ACRONYMS**

<b>ASFR</b>	:	Age Specific Fertility Rate
<b>ASHR</b>	:	Adolescent Sexual and Reproductive Health Policy
<b>GDP</b>	:	Gross Domestic Product
<b>KDHS</b>	:	Kenya Demographic and Health Survey
<b>KFFNPR</b>	:	Kaiser Family Foundation, National Public Radio
<b>MoH</b>	:	Ministry of Health
<b>NGOs</b>	:	Non-Governmental Organizations
<b>SDGs</b>	:	Sustainable Development Goals
<b>S.E.K.U</b>	:	South Eastern Kenya University
<b>SPSS</b>	:	Statistical Package For Social Science
<b>SRH</b>	:	Sexual and Reproductive Health
<b>T.V</b>	:	Television
<b>WHO</b>	:	World Health Organization

## OPERATIONAL DEFINITION OF TERMS

<b>Abstinence:</b>	Refraining from sexual activities.
<b>Adolescence:</b>	Defines the age between ten (10) and nineteen (19) years and is considered the transitional stage from childhood to adulthood. It can start as early as nine years.
<b>Puberty:</b>	Is a period in which adolescents attains sexual maturity and become capable of reproduction.
<b>Sexual maturity:</b>	Refers to the capability of an organism to reproduce.
<b>Teens:</b>	Boys/girls between the ages of 13-19 years.
<b>Adolescent pregnancy:</b>	The pregnancy of a girl who is under the age of 18 years.
<b>Unintended pregnancy:</b>	Refers to unplanned pregnancies, which include mistimed and unwanted pregnancies.

## ABSTRACT

The future of society depends on teenagers. The transition of teenagers to successful adulthood depends on their gender and other societal forces. The handling of the teenager's issues influences their future excellence. The female gender is more susceptible to many challenges which may hamper their bright future. Girls more so on their teenage face greater challenges compared to their boys' counterparts. Girls are prone to challenges of sexual reproductive health and pregnancies which may blur their social, economic cultural and health outcomes. It is therefore worth noting the importance placed on teenage pregnancies. This research, therefore, sought to determine the socio-cultural drivers of adolescent pregnancies among school-going girls in Kitui township sub-location, Kitui county, Kenya. A sample of 140 teenagers was enumerated from a larger population of 467 available interviewees as per Kerlinger (2004). The study adopted a mixed-method cross-sectional research design, which involves combining qualitative and quantitative design methods. The data was collected using questionnaires, Key informants' guides and focused group discussions. The quantitative data was analyzed using SPSS and presented in tabular and in form of graphical illustrations. The qualitative data was presented in form of verbatim quotes. Over half (66%) of the girls' population was knowledgeable and the larger source of their knowledge was teachers. 50% of the population had boyfriends and termed the move as their choice after peer influence. The study findings give the current teenage pregnancies landscape and also can be used for regulatory and advisory purposes by bodies which deal with girl child welfare like UNICEF. The study concluded that the rising pregnancies were linked to peer pressure, social opposition and gender norms and recommended awareness among the girls and their parents to minimize teenage pregnancies.

## CHAPTER ONE

### 1.0 INTRODUCTION

#### 1.1 Background of Study

Adolescent pregnancy has been a rampant problem in various countries in the world. Although the world's teenage birth rate has dropped from 65 births for every 1000 women in 1990, to 47 births per 1000 women in 2015 (UN DESA, 2015) the numbers are still high. Globally, 11% of births occur annually among adolescents aged 15-19, 95% of which occur in developing countries. Available estimates indicate that about 19% of adolescents in developing countries become pregnant before the age of 18. In absolute numbers, 13.1 million births per year occur among adolescents aged between 15-19 years (UNFPA, 2013). Of these, only 680,000 take place in developed countries. Among the developed countries, the highest adolescent birth rates of 194,377 births have been recorded among adolescents between 15-19 years in 2017 in the United States (Martin J.A, 2018). Among the states forming the Organization for Economic Cooperation and Development, of which some middle-income countries are included, Mexico records the highest birth rates (64.2 per 1000 births) among adolescents aged 15-19 years, while Switzerland is the lowest at 4.3 births per 1000 women (Martin J.A, 2018).

Globally, the highest fertility rate is reported in Sub-Saharan Africa at 143 births per 1000 girls aged between 15-19 years (WHO, 2014). Save the Children report reveals 10 countries where early motherhood presents a high prevalence of risks in young girls and their babies. Of the countries cited, nine were in Sub-Saharan Africa, with Mali, Niger and Liberia being the nations where girls are the most at risk (UNFPA, 2013). In countries reporting the highest risks, more than 1 in every 6 teenage girls ageing between 15-19 years gave birth per year and nearly every 1 in 7 newborns died before the age of 1 year making pregnancy and child bearing the foremost causes of death among teenage girls in developing countries. The projection of births by girls under 15 years in Sub-Saharan Africa estimate the numbers to double in the next 17 years, meaning by the year 2030, the numbers of teenage mothers below the age of 15 years might be equal to those in South Asia (UNFPA, 2013).

In Kenya, the adolescent birth rate is at 18 per cent (15% of all adolescent girls have already given birth and 3% are expectant for their first child) translating to 96 births per 1000 women (K.D.H.S, 2014). Although Kitui as a County is not ranked amongst the highest with adolescent pregnancies in the country it still falls among the double digits at a worrying 14.8 per cent (K.D.H.S, 2014) with 11.8 per cent of adolescents, aged 15-19 have already given birth at least once and 3 % are already expecting their first child.

The proportion of adolescents who have begun childbearing has not changed since the 2008-2009 KDHS report. Teenage pregnancy and early motherhood are still a major health and social concern because of their association with maternal and child mortality and morbidity, psychological and emotional distress, as well as other educational and socio-economic implications for the life opportunities of young mothers and their children. According to UNFPA, 2013; Motherhood in Childhood report, when a girl becomes pregnant or has a child, her health, education, finances and entire future may be at risk of being trapped in a lifetime of poverty, exclusion and powerlessness. Eventually, this takes a toll on her family, the community, the economy and the growth and development of the nation. The health impact may include risks of maternal death, illness and disability, including obstetric fistula, complications from unsafe abortion, sexually transmitted infections including HIV, and health risks to infants. The educational impacts include the interruption or termination of formal education hence lost opportunities to realize their full potential. The economic impact is closely associated with the educational impacts and may include exclusion from paid employment, additional costs to health services and eventual loss of human capital. All in all, the issue of adolescent pregnancies is seen to escalate the cycle of poverty in the country. The government, therefore, needs to deal with reproductive health issues to fast track the achievement of the Sustainable Development Goals (SDGs), whereby easy and equitable access to sexual health forms part of the universal goals that are to be attained.

The Kenyan government has made efforts to reduce the rates of adolescent pregnancies for example through the formulation of the National Adolescent Sexual and Reproductive Health Policy (ASRH-2015). The core mandate of the policy is to improve the life quality

of Kenya's youths and adolescents through merging the development and health concerns of the youth in the national development process. This policy saw a significant increase in the rates of contraceptive use among the youth leading to reduced cases of adolescent pregnancies. Abstinence programs were also initiated to deal with the issue. However, according to Ahorlu, Pfeiffer and Obrist (2015), abstinence-only programs are described as unrealistic because they tend to overlook the fact that sexual behaviour/expression is an instrumental aspect of healthy human development for persons of all ages. In other words, abstinence-only programs have been portrayed as ineffective in curbing the prevalence rates of adolescent pregnancies because they only seek to delay the onset of sexual intercourse among adolescent girls, but do not seek to address the prime drivers of adolescent pregnancy.

Although there have been many studies on adolescents, there are several gaps in knowledge on extant studies. First most researchers have shied away from covering sensitive topics such as sex and pregnancy among young adolescents (10-14) either because of social norms concerning age-appropriate behaviours, ethical concerns about potential harmful effects of the study on adolescents or doubts about the validity of young adolescent responses (Chong et al., 2006). In addition, most of these studies are population-based, for example, Shiateya (2016), as opposed to institution based; meaning evidence based on schools or learning institutions is limited. Third, most of these studies such as Demographic and Health Surveys (DHS) are quantitative and their samples have a rural bias given the low level of urbanization in African Countries. Moreover, the DHS target population are on women aged 15-49. As such first hand and qualitative data on very young adolescents (10-14) in the urban setting are scarce, incomplete or non-existent for many countries, rendering the girls and the challenges they face invisible to policy makers (UNFPA, 2013). To help bridge these knowledge gaps this study adopts a mixed methods design to investigate socio-cultural drivers of adolescent pregnancy among girls aged 10-18 in schools in an urban setting in Kitui County, Kenya.



## **1.2 Statement of the Problem**

Adolescent pregnancy and motherhood have remained a major health and social concern because of their association with higher morbidity and mortality for both the mother and her child. (K.D.H.S, 2014). The Convention on the Rights of the Child states that anyone under 18 years is considered as a 'child'. Therefore, girls who fall pregnant before this age (18) tend not to enjoy their rights to health, education and good living standards. These are all basic human rights.

Despite government efforts, adolescent fertility rates in Kenya are still unacceptably high at 18% (K.D.H.S 2014). It should be noted that efforts and large resources to control the increasing rates of adolescent pregnancies are usually focused on 15 to 19-year-old girls. This happens despite the most vulnerable being 14 or younger. Moreover, the possibilities of 14-year-old girls dying from pregnancies or facing other birth complications are higher than the older adolescents. Most adolescents getting pregnant at this tender age tend to do so in the confines of forced marriages hence are prevented from going back to school or gaining access to sexual and reproductive health facilities and services. Due to their young age, their needs are inevitably numerous; therefore, the governments and general communities should offer support and protection to ensure a safe and healthy transition from adolescence to adulthood. Qualitative and quantitative data on adolescent pregnancies below the age of 14 is usually incomplete, scarce or non-existent for most countries which make the challenges faced by these young girls almost invisible to those charged with policy making. Apart from collecting data to build on the scanty data available for ages 10-15, additional data on ages 15-18 were also collected with a focus on adolescents in Kitui Township sub-Location, Kitui County.

## **1.3 Objectives of the study**

The main objective of this study was to investigate the socio-cultural drivers of adolescent pregnancies among school-going girls in Kitui Township, sub-location, Kitui County.

#### **1.4 Specific Objectives**

The research sought to achieve the following specific objectives:

- i. To investigate the extent to which inadequate sexual and reproductive health knowledge contributes to adolescent pregnancies among students in Kitui Township, Kitui County.
- ii. To examine the extent to which peer pressure contributes to adolescent pregnancies in Kitui Township, Kitui County.
- iii. To determine the extent to which social opposition to the provision of sexual and reproductive health information and services contribute to adolescent pregnancies in Kitui Township, Kitui County.
- iv. To determine how gender ideology in sexual and reproductive health affects adolescent pregnancies in Kitui Township, Kitui County.

#### **1.5 Research Questions**

- i. To what extent does inadequate SRH knowledge contribute to adolescent pregnancies among students in Kitui Township, Kitui County?
- ii. To what extent does peer pressure contribute to adolescent pregnancies in Kitui Township, Kitui County?
- iii. How does social opposition to the provision of SRH information and services contribute to adolescent pregnancies in Kitui Township, Kitui County?
- iv. How does gender ideology affect adolescent pregnancies in Kitui Township, Kitui County?

#### **1.6 Justification of the Study**

The results of this research will benefit the authorities at the Ministry of Health in Kitui County, parents and future researchers in this field. First, it will provide insights into the prime causes of adolescent pregnancies in subsets of Kitui County. This will assist the policy makers at the MoH to formulate policies of curbing the escalating rates of adolescent pregnancies in the entire region of Kitui County.

Secondly, the study will keep potential parents in the know as far as; the topic of adolescent pregnancies is concerned. For example, it will provide them with an understanding of what they need to do to reduce the susceptibility of adolescents to early pregnancies.

Lastly, during the course of this research, some vital information on the subject of adolescent pregnancy was availed. Future researchers can capitalize on such information to delve further into the factors influencing adolescent pregnancy.

### **1.7 Limitations of the study**

The main limitation of the study was that girls of less than thirteen years who were not attending school were not be captured in this study. In addition, since the adolescents were required to provide details of their own experiences through self-report collected through the questionnaires, issues of biases could arise. Selection bias was also experienced, as the samples are school-based as compared to household samples. In addition, data collected was not considered general to all adolescents, meaning those in and out of school.

## **CHAPTER TWO**

### **2.0 LITERATURE REVIEW**

#### **2.1 Introduction**

Research on the factors influencing adolescent pregnancies among school-going girls has been an outcome of focus for a previous empirical study on the effectiveness of abstinence-only programs. According to Ferriman (2009), this has escalated the rate of adolescent pregnancies since the abstinence-only programs do not appreciate the fact that sex is a formidable part of human development. However, despite there being a huge void of research on factors influencing adolescent pregnancies among school-going girls, few types of research, as well as theoretical frameworks, have highlighted views on this vital subject. The views of such scholars will be reviewed in this section. It will outline a discussion on the concept of adolescent pregnancies, theoretical framework, as well as the findings of previous empirical research on this subject.

#### **2.2 The Concept of Adolescent Pregnancy**

In the contemporary world, the aspect of adolescent pregnancy has become a media focal point as well as a public health issue. According to Gandhi, Sharma and Gite (2011), the aspect of adolescent pregnancy has become repetitive because in Sub-Saharan countries more than 50% of mothers give birth below the age of 18. This is a high rate of teenage pregnancy because in regions such as the Caribbean and Latin America only 33% of mothers give birth below the age of 20. Various jurisdictions perceive the aspect of adolescent pregnancy differently. For instance, most countries in the sub-Saharan region including Kenya defines teenage pregnancy as the pregnancy of a girl who is between the age of 10 and 18 years. However, from the perspective of WHO, 'Adolescent or adolescent pregnancy illustrates the pregnancy of a girl who is aged between 10 years to 17 years,' (WHO, 2017).

The puberty years are an important part of human life since it marks the beginning of sexual maturity. For this reason, girls at the age of 13 and 18 years tend to become curious on matters of sexuality and therefore end up being susceptible to early or unwanted pregnancies. Ferriman (2009) explains that the rates of adolescent pregnancies in

developed countries have fallen whereas in sub-Saharan countries rates of adolescent pregnancies continues to surge above 50%. This could be attributed to the huge focus placed by African authorities on abstinence-only programs. For example, Hyder (2009) explains that school-going girls in Kenya are only being told to refrain from pre-marital sex. However, to end the menace of adolescent pregnancy, the subject of pre-marital sex should not be shrouded with abstinence-only programs.

According to Gandhi, Sharma and Gite (2011), abstinence-only programs are ineffective in curbing the prevalence rates of adolescent pregnancies because they only seek to delay the onset of sexual intercourse among adolescent girls but do not seek to address the prime drivers of adolescent pregnancy. Also, teenage pregnancy is a public health issue because the bodies of school-going girls at puberty years are not prepared psychologically and physically to cope with the consequences of adolescent pregnancy. A study by Laari and Laar (2016) revealed that adolescent mothers face a heightened risk of obstructed labour compared to women in their twenties. According to the authors, without ample emergency obstetric care, obstructed labour could lead to uterine rupture as well as heightened risk of death for both the infant and the mother. Lack of sensitization of teens on the consequences or health risks on the subject of adolescent pregnancy has compelled this research to delve into the extent to which inadequate sexual knowledge and peer pressure contributes to early or unwanted pregnancies among school-going girls.

### **2.3 Inadequate Sexual and reproductive health Knowledge as the cause of Adolescent Pregnancy among School Going Girls**

Previous empirical research on the relationship between inadequate sexual knowledge and adolescent pregnancy among school-going girls falls into two groups of schools of thought: Comprehensive sexual education and abstinence-only programs. There is debate over which method is most human and which method is most efficient. Scholars in the camp of abstinence-only programs posit that comprehensive sexual education falls under the emblem of inadequate sexual knowledge because they tend to send a conflicting message concerning sex behaviour to teens, thereby confusing them.

According to Taffa and Matthews (2003), this deters comprehensive sexual education programs from having a significant and positive effect either on the use of contraceptives, condom or on abstinence. Research conducted by Mesatywa, Chikungwa and Kabasa (2013), proponents of the abstinence-only program, in South Africa revealed that the principal way to minimize teen pregnancy, as well as rates of sexually transmitted infections among teens, is to postpone the onset of sexual commencement as well as the percentage of adolescents that are sexually active. According to the authors, this can only be done by relaying a consistent education on abstinence and ensuring that students are not confused with information concerning contraception, thereby indirectly inspiring them to forsake or neglect abstinence. Conversely, according to scholars in the other camp, comprehensive sexual education tends to insinuate that effective sexual education should draw on prevailing knowledge of best practices, which are aimed at attaining the stated goals, in this case, taming the escalating rates of teen pregnancy. For this reason, Pati and Tekie (2016) assert that abstinence-only programs fall under the emblem of inadequate sexual knowledge because it is embedded in the notion that abstinence is the only program that is 100% efficient at taming the escalating rates of adolescent pregnancy.

In reality, however, abstinence as a method of birth control can and does fail routinely more often actually than any other method of birth control as evidenced by the fact that 95% of Africans have had premarital sex (Willcox and Gleeson, 2003). In concurrence with this, research conducted by Hyder (2009) revealed that the present median age of sexual initiation is 17 whereas the average age of marriage is 25.8 for women and 27.4 for men. According to the author, this leaves eight to ten years on average between the onset of sexual activity and marriage. Also, the author found that even among those who abstained from sex until age 20 or older, 81% have had premarital sex by age 44. Moreover, research conducted by Ferriman (2009) also found that abstinence-only programs did not have an impact on desirable behaviour outcomes since they did not delay the onset or initiation of sexual behaviour among teens or even tame the escalating rates of teen pregnancy and sexually transmitted infections. The researchers further disclosed that abstinence-only respondents started their first sexual experience below the age of 18 and only 15% of them admitted to using a condom or contraceptive when having sex.

Empirically, there is a wide negation of the effectiveness of abstinence-only programs in reducing or taming the escalating rates of adolescent pregnancy. However, Taffa and Matthews (2003) assert that it is not the characteristic ineffectiveness of abstinence that contributes to the ineffectiveness of these programs, but how they teach sexual education. Scholars in comprehensive sexual education suggest that sexual education should be embedded in the objective of fostering sexual health. However, Pati and Tekie (2016) assert that since the abstinence-only programs by definition refuse or negate even to recognize other methods of contraception besides abstinence, these programs are depriving school-going girls' fundamental knowledge concerning sexual health.

A comprehensive study conducted by Silka and Albright (2013) examined the effects of variant sexual education policies in Kenya. This research was carried out in 2006 when abstinence-only programs were at the highest point in Kenya. The research found that only 70% of teachers presented birth control as an effective means of deterring adolescent pregnancy, while 28% emphasized abstinence, and 2% did not teach about them at all. This reveals that many life educators are beginning to view abstinence as an ineffective tool for taming adolescent pregnancy. From the above analysis, it is clear the abstinence-only programs have not succeeded in reducing the involvement of teens in early sexual behaviour. One of the most fundamental criticisms of abstinence-only programs is primarily lack of public support or trust. In concurrence with this, McGill (2014), a research conducted in 2003 by the KFFNPR (Kaiser Family Foundation, National Public Radio) as well as by the Harvard University found that only 10% of Americans believe that school-going children should be taught abstinence from early sexual engagement. Also, among the individuals in the 10% believed that abstinence-only programs should not relay information on the usage of condoms or contraception (Kirchengast and Belizan, 2009). However, another research conducted by Silka and Albright (2013) revealed that 82% of US adults supported comprehensive programs, while abstinence-only received the lowest level of support (36%) and the highest levels of opposition (50%).

Lastly, in almost all instances where comprehensive sex education programs have been studied researchers have found that the programs have had some significant and positive

effect on postponing the commencement of sexual activity, reducing pregnancy rates as well as decreasing sexual risk-taking. For example, a study conducted by Ferriman (2009) revealed that, where comprehensive sex education program was taught, 21% fewer boys and 34% fewer girls had disengaged from sexual activities by the time they reached the eighth grade, compared to the girls and boys in comparison schools. These results are pretty extraordinary when you consider the multitude of other factors contributing to adolescent sexual behaviour such as peer pressure and they strive to depict that sexual education programs can have a significant and positive difference as well as to portray the inefficiency and ineffectiveness of abstinence-only programs.

#### **2.4 Effects of Peer Pressure on Adolescent Pregnancies**

It has been proved empirically and theoretically, that peer pressure is a formidable force that continues to exert enormous influence among teens to engage in sexual relationships or in romantic relationships. Previous researchers have shown that peers influence their fellow peers by modelling behaviours as well as setting social norms. In the context of social learning theory, peer pressure is perceived as positive reinforcement, which leads to the formation of new behaviours such as watching adult films and engaging in sexual or romantic relationships. A study conducted by Kurbatova and Valova (2015) provided evidence that peer pressure is more often positive than negative reinforcement. That is, using data from the National Longitudinal Study of Adolescent Health (Add Health, 1994-95), the authors sought to explain peer effects on girls' sexual debut and pregnancy risk. To determine the independent effect of peers on these two variables, the authors controlled for other factors associated with adolescent sexual activity and pregnancy risk. The findings of the study indicated that peer pressure has a huge influence on the network of friends. Moreover, research conducted by Willcox and Gleeson (2003) used questionnaires to find out the influence of peer pressure on adolescent pregnancies. According to the findings of the research, 67% of the participants concurred that peer pressure is a principal cause of adolescent pregnancy. This research finding is consistent with the sentiments of Lovel, Antwi and Nottage (2007) who posited most adolescents rely on their peers for information and this makes them fall culprit of early or unwanted pregnancies. Moreover, other studies such as Hyder (2009) have revealed that the larger peer group, or clique,



exerts a mix of influences on adolescent pregnancy as well as sexual debut. According to the findings by the authors, as the number of high-risk members in a girl's peer group escalates, so does her chances of adolescent pregnancy and risk of sexual debut. For this reason, the authors concluded that a clique composed primarily of high-risk members can act as positive differential reinforcement. That is, a clique of high-risk members can compel a girl to form new behaviours such as engagement in sexual behaviours and watching adult films. Conversely, as the number of low-risk members in her peer group rises, a girl's chances of getting pregnant decrease.

### **2.5 Social opposition to Contraceptive use and Adolescent Pregnancy.**

According to World Bank, 2010, 50 per cent of female adolescents in Sub-Saharan Africa are unable to access family planning resources due to demand exceeding supply. The biggest proportion of those unable to gain access is highest among the married female adolescents than among the unmarried sexually active adolescents (United Nations, 2013). This results to increased use of contraceptives among unmarried sexually active adolescents whose demand for contraceptives is less satisfied as opposed to their married counterparts. The current rate of use of contraceptives stands at 10.1 per cent (K.D.H.S, 2014). Contraceptive use in Kitui county is at 57.3 per cent (K.D.H.S, 2014) just slightly shy of the national level which stands at 58.0 per cent.

In a study on the barriers to modern contraceptives in Kenya by Ochako, 2015, the major hindrance to the use of modern contraceptives among adolescent girls is the myths that these young girls are taught, in which they learn about both the myths and their factual side effects from their social se-ups.

Another study by Kinaro, 2015 on the perceptions and barriers to contraceptive use among adolescents aged 15-19 years in Kenya, concluded that hostile attitudes from peers on contraceptives is not the only factor affecting the use of contraceptives among adolescents. In addition to this, other influences such as the negative attitude on contraception use by parents and teachers contribute greatly to the low numbers. This could be in various ways

such as minimal if any sexual spouse communication, inability to look for these contraceptives and the negative perception of contraceptive use by adolescents.

Furthermore, there is a lack of capacity by contraceptive providers to fully meet the demand and they also tend to have negative attitudes particularly in supplying contraceptives to young people (Nalwada, 2012; Estelle M Sidze, 2014). In her study, examination of the prevalence of protective eligibility restrictions, which was based on age and marital status specifically among family planning providers based in Senegal, Estelle Sidze believed that the suppliers probably set the lowest age limits for the pill and injection which are two of the most used methods by young women (Sidze, 2014). In other cases, the challenges faced have been more system based where contraceptive use and provision to young people were hindered by lack of regular stocks of contraceptives, insufficient numbers of qualified workers, lack of friendly services or the high costs. As a result, this indicates that challenges to contraceptive use are not only on the individual level, but also on the levels of service providers, therefore experiences faced by adolescents with those who provide family planning services in accessing their preferred choice of contraceptives should also be included.

## **2.6 Gender Ideology and Adolescent Pregnancy.**

The term gender refers to socially constructed beliefs on how men and women should act or behave. The reasons as to why adolescents choose to abstain or engage in sexual activities and also use contraception vary based on the different gender ideologies that surround the adolescents' environment. For example, the social expectations from peers and family members, the different roles defined within the different relationships and the gender empowerment gaps.

The beliefs tend to be continually included in the social messages targeted at adolescents. In Gage AJ (1998) Sexuality activity and Contraceptive use: the components of the decision-making process, a man's sexual promiscuity and virility are highly valued even if they value monogamy or abstinence from sex. According to Pleck JH, Sonenstein FL, Kulc (1993) socially constructed beliefs about femininity often encourage virginity and

discourage sexual activities for young women but beliefs about masculinity often encourage the opposite. In Gage AJ (1998) gender ideologies also play a role during contraception decision making and behaviour. For example, cases where female adolescents follow their individual cultural beliefs in practicing abstinence from sex. Furthermore, they are expected to be passive in their knowledge of sexual activities. These beliefs discourage the use of contraceptives and as a result, many girls report their first encounters being unplanned.

Carpenter L.M (2005) relates contraception use to the strong desire for intimacy in relationships, often shown through not using contraception in the hopes of discouraging their partners from seeking other sexual outlets. In addition, Pleck J H et al, (1993) asserts that adolescent males are more likely to point out that using birth control is a woman's responsibility, especially if they adhere to traditional attitudes of masculinity.

## **2.7 Theoretical Framework**

### **2.7.1 Socio- Ecological Theory**

The socio-ecological model for understanding human development was initially developed by Urie Bronfenbrenner in the 1970s and later formalized as a theory in the 1980s. The main tenet of the socio-ecological model is that individual behaviour is an outcome of the interaction between personal, social and environmental factors. According to this theory, individual behaviour is shaped by the individual, interpersonal, community, organizational, and policy environment. Robert Blum from Johns Hopkins Bloomberg School of Public Health in (UNFPA ,2013) explains the likelihood of adolescent girls getting pregnant is increased by a constellation of forces that conspire against her. Although these forces are many and multi-layered, more often than not, they tend to interfere with the girls' ability to enjoy or exercise individual human rights and empower them to shape their future.

Robert Blum explains how various determinants in the ecological model operate at more than one level, such as at the national level policies may restrict adolescents' access to sexual and reproductive health services including contraception, while the community or family may oppose girls accessing comprehensive sexuality education or other information

about how to prevent pregnancy (UNFPA, 2013). The model shows that adolescent pregnancies do not occur in a vacuum but are the consequence of an interlocking set of factors such as widespread poverty, communities' and families' acceptance of child marriage and inadequate efforts to keep girls in school (UNFPA, 2013).

At the national level, the following determinants in terms of national laws and policies tend to contribute greatly to increased adolescents' pregnancies: Laws limiting access to contraception; unenforced laws against child marriage; Economic decline (poverty); Underinvestment in girls' human capital; Political instability, humanitarian crises and disasters.

Community-level forces encouraging adolescent pregnancies include Negative attitudes about girls' autonomy; Negative attitudes about adolescent sexuality and access to contraception; Limited availability of youth-friendly services; Absence of antenatal and postnatal care for young mothers; Climate of sexual coercion and violence.

At the school or peer level, the major contributors of adolescent pregnancies include Lack of information or no access to quality comprehensive sexuality education; Peer pressure; Obstacles to girls' attending or staying enrolled in school; Partners' negative gender attitudes and risk-taking behaviours.

The family level is mainly affected by negative attitudes and behaviours specific to each family such as Negative expectations for daughters; Little value on education, especially for girls; Favourable attitudes to child marriage.

### **2.7.2 Social Learning Theory**

As suggested by Bandura in the 1960s and 1970s, the social learning theory is embedded in three determinants of human behaviour, that is, behavioural, cognitive as well as environmental factors. In other words, individuals such as teens learn new behaviours by watching behaviours of other people, absorbing them and imitating those behaviours. In gender studies, social learning theory has been applied to clarify matters such as sexual

education, adolescent pregnancy, health education, abuse prevention as well as violence prevention. In regards to the subject of adolescent pregnancy, the social learning theory has put forward an array of views that are in tandem with the objectives of this study.

First, the proponents of social learning theory admit that premarital sex or engagement in early sexual behaviours by teens is primarily an outcome of inadequate sexual knowledge. Regarding this, Hyder (2009) concurs that teens in sub-Saharan countries receive few, if any, positive models for healthy sexual behaviour. In this case, modelling positive, as well as healthy sexuality-related behaviour to teens, is extremely important since it puts them abreast with the health risks associated with unhealthy sexual behaviour. Since sexual activity frequently happens in private places or settings, much of what youth know about sex is derived from TV stations, popular music, magazines, and movies. According to Kimemia (2016), the information aired in the aforementioned places (TVs, Movies) tends to model youth behaviour towards early sexual activities, and violence combined with immoral sex. In other words, the content aired in movies and celebrity magazines is a contradiction of what most life educators on sex are trying to teach the teens. This is because such contents are void of healthy sexual behaviours such as delayed sexual activity, protection and health risks associated with early or unwanted risks. The proponents of social learning theory explain that the gap in sexual education is to blame for the escalating rates of adolescent pregnancies among school-going girls.

Moreover, Kirchengast and Belizan (2009) further explain that the four fundamental premises of social learning theory can be used to understand the occurrence as well as the reoccurrence of adolescent pregnancy. In other words, the four fundamental premises, that is, differential association, differential reinforcement, imitations, and definitions, can be utilized to explore the variant aspects within the life of adolescent moms and drivers that lead to their pregnancy. First, the inclination of celebrity magazines and movies towards early sexual activity can be described as differential reinforcement. In this case, Kimemia (2016) explains that differential reinforcement is the process by which individuals anticipate and experience the consequences/outcome of their actions. In many instances, media content tends to portray to youths or teens that the consequences of early sexual

behaviour are pleasant. This tends to reinforce the occurrence as well as the occurrence of sexual behaviour among school going teens. Furthermore, social learning theory posits that reinforcement of values, beliefs, and attitudes acquired through imitation and differential association (peer pressure) can be either negative or positive. In this case, peer pressure and environment act as positive reinforcements since they increase or compel the teens to engage in sexual behaviour. According to Kurbatova and Valova (2015), positive reinforcement will in many instances encourage the occurrence and reoccurrence of the same behaviour by painting or depicting pleasant rewards and outcomes.

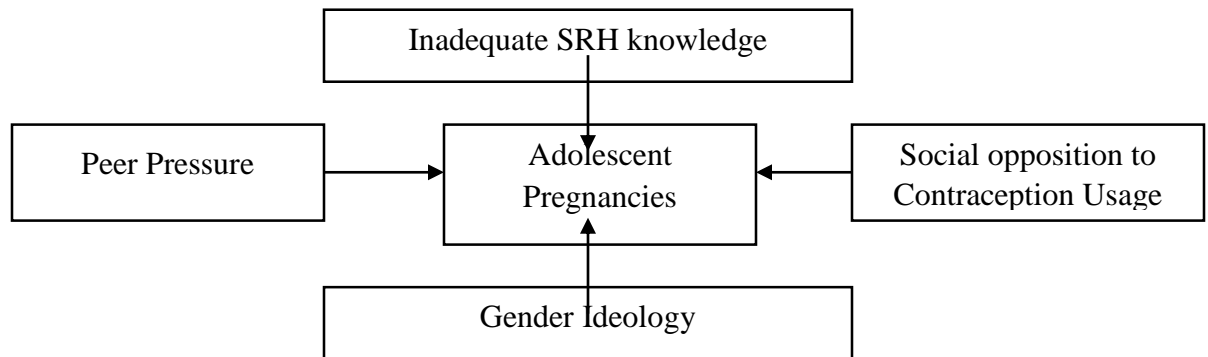
On the other hand, the efforts of life educators act as negative reinforcement since they try to impede the occurrence and reoccurrence of adolescent pregnancy by educating teens on the harsh and health risks associated with early pregnancy. However, Lovel, Antwi and Nottage (2007) assert that the exposure of teens adult content tends to counter the efforts of life educators in taming rates of adolescent pregnancy. Moreover, imitation, a fundamental premise of social learning theory, indicates that individuals involve themselves in behaviours that they previously witnessed from others. In concurrence with this, Akers and Sellers (2004) explain that individuals observe characteristics of role models, their behaviour, and the outcome of their behaviours, and then imitate them. To a large extent, scholars in human psychology concur that individuals to whom one is in immediate contact are the number one source of imitation.

From the analysis of social learning theory, two factors that influence adolescent pregnancy can into play. That is peer pressure and the gap in sexual education. The mentioned factors are responsible for modelling youth or teen behavior towards early sexual activity, which may influence early adolescent pregnancy. Although there have been formidable efforts from life educators to curb the escalating rates of adolescent pregnancy using campaigns such as “No to pressure to have sex”, the involvement of teens in sex continue to surge. McGill (2014) explains that the use of abstinence-only programs has been portrayed as ineffective in curbing the prevalence rates of adolescent pregnancies. This is because they only seek to delay the onset of sexual intercourse among adolescent girls but do not seek to address the prime drivers of adolescent pregnancy such as imitation from peers, and

positive reinforcements from the environment. Moreover, most societies in African contexts do not allow life educators to teach teens methods of hampering early pregnancies. In other words, Lovel, Antwi and Nottage (2007) explain that in the area of sexuality, teens often do not get a chance to "practice" these prevention skills before they are in the actual situations where they need them. Teaching youth-specific behavioural skills is crucial in an effective prevention program. Unfortunately, many sexuality programs such as abstinence-only programs emphasize cognitive learning and fail to address the behavioural aspects of becoming and staying sexually healthy.

## 2.8 Conceptual Framework

A conceptual framework is a structure, which the researcher believes can best explain the natural progression of the phenomenon to be studied (Camp, 2001). It shows the series of action the researcher intends to carry out in a research study (Dixon, Gulliver & Gibbon, 2001). The framework makes it easier for the researcher to easily specify and define the concepts within the problem of the study (Luse, Mennecke & Townsend, 2012).



**Figure 2.1 Conceptual Framework**

The study was guided by social learning theory which combines behavioral learning theory and social cognitive theory. This theory urges that learning is influenced by psychological factors according to Bandura, 1977

## **2.9 Summary**

The above analysis has a literature review on the subject of factors influencing adolescent pregnancies. According to the above literature, abstinence-only programs fall under the emblem of inadequate sexual knowledge because it is embedded in the notion that abstinence is the only program, which is 100% efficient at taming the escalating rates of adolescent pregnancy. In reality, however, abstinence as a method of birth control can and does fail routinely. The lack of sensitization of teens on the consequences or health risks on the subject of adolescent pregnancy has compelled this research to delve into the extent to which inadequate sexual knowledge and peer pressure contributes to early or unwanted pregnancies among school-going girls. From the analysis of social learning theory, two factors that influence adolescent pregnancy come into play. That is peer pressure and the gap in sexual education. These factors are responsible for modelling youth or teen behaviour towards early sexual activity, which leads to early adolescent pregnancy. However, the gaps in sexual knowledge, an outcome of abstinence-only programs, and inadequate efforts to tame the formidable force of peer pressure in intensifying rates of adolescent pregnancies have motivated the undertaking of this study.



## **CHAPTER THREE**

### **3.0 METHODOLOGY**

#### **3.1 Introduction**

This chapter is an outline of the various methods that were used to carry out the study. The chapter details the methods and materials required for data collection and analysis. The chapter also introduces the study area, research design, target population, sample size, research tools and sampling procedures followed during the research. Ethical compliance has also been included in this chapter.

#### **3.2 Research Site**

This research was carried out in Kitui township sub-Location, Kitui County, Kenya. The area is approximately 17.9 square kilometres with an approximate population of 26, 016. Kitui township sub-location, Kitui County is located in the Eastern region of Kenya. It is among the following sub-locations that form the larger Kitui Township Sub-Location :Kalundu, Majengo/Manyenyoni, Kaveta/ Syongila and Katyethoka/ Ngiini. The majority of the economic activities is based on subsistence farming despite the challenges from sporadic rainfall. As a result, most of the residents engage in small businesses such as butcheries, selling food staples (rice, corn meal), mini markets (selling goods like coca-cola, potato chips, bread, long-shelf milk), mechanics, pubs, hotels and restaurants. Also situated in Kitui town is a cotton ginnery where cotton farmers from the county can deliver their produce. It's the only main industry in the region, set up in 1935. Kitui is mainly a semi-arid area and many crops apart from cotton, do not fare well, hence the ginnery being the major income-generating activity in the region.

#### **3.3 Research Design**

The study adopted a mixed-method cross-sectional research design, which involves combining qualitative and quantitative design methods. The study employed quantitative and qualitative methods concurrently for triangulation. The concurrent triangulation design involved a one-phase mixed-method study in which researchers employed both quantitative and qualitative methods during the same timeframe and with each method having equal weight. The reason was for the quantitative and qualitative methods to collect

complementary data on the same study topic to enable the researcher to compare and contrast the two results to best understand the research problem (Creswell, Plano Clark, et al., 2003).

The quantitative data were collected using a questionnaire-based survey. The purpose of the quantitative data was to provide numeric data on the magnitude of adolescent pregnancy and associated factors. The type of quantitative data collected included; the magnitude of sexually active adolescents, use of contraceptives, abortion, maternal health among sexually active adolescents and other numerical information on SRH knowledge. The qualitative method gathers in-depth and detailed non-numerical data, through focus group discussions and Key informant interviews. Examples of qualitative data collected include their narratives of SRH issues such as, how adolescents tend to perceive the issue of contraceptives and sex in relation to peer pressure or gender, circumstances of their sexual debut and sexual negotiation and collaborating.

### **3.4 Target Population**

The target population of this research encompassed adolescents aged between 10-18 years in Kitui Township sub-location, Kitui County. The population included current students of Central Primary School and Muslim Secondary School, which is a mixed school. At least six (10) teachers formed the panel of key informants for the study. Five teachers were selected from each school, the number included two administrators, and 3 teachers, 2 male teachers and one female teacher from each school, this was mainly meant to provide a gender perspective on the problems of adolescent pregnancies in the schools.

### **3.5 Sample Size and Sampling Procedures**

Mugenda and Mugenda (2003), the main consideration determining sample size is the capability to collect in-depth data at affordable costs in terms of time, finance and resources. According to Kerlinger (2004), an ideal sample size should be between 10%-30%, depending on the data to be gathered and analyzed. Therefore, from a target population of 467 available students, 167 students from Central primary school and 300 students from Muslim secondary school were selected. A sample size of 140 students

(30%) was derived using Slovin 2013 mathematical relation as shown below to participate in the study.

$$n_f = \frac{N}{(1+Ne^2)}$$

3.1

Where;

$n_f$  = desired sample size for target population less than 10,000

$N$  = Population size

$e = 0.05$  is the margin of error (M.o.E) in this case  $e = 0.05$

Therefore;

$$n_f = \frac{467}{\{1 + (467 \times 0.05^2)\}}$$

$$n_f = \frac{467}{\{1 + (2.335)\}}$$

$$n_f = \frac{467}{(1 + 2.335)}$$

$$n_f = \frac{467}{(3.335)} = 140$$

Simple stratified sampling was used to classify the 467 - primary school students into five different strata depending on their class levels. From each stratum, simple random sampling was used to select individual respondents. Simple random sampling was operationalized by writing Yes and No on pieces of paper in a lottery. Those who picked the Yes papers in a lottery were selected as respondents. In total, 60 primary school respondents were selected. Those who picked NO were not allowed to participate in the study and they went back to classrooms.

The same simple stratified sampling was applied in secondary school where the 80 respondents were grouped into 4 strata according to their class levels after which simple random sampling was used to select specific respondents using the same lottery explained above. Purposive sampling was used to select teachers who participated as the key informants for the study.

### **3.6 Data Collection Instruments**

#### **3.6.1 Questionnaires**

The researcher with the help of two research assistants conducted interviews using questionnaires containing both open-ended and closed-ended structured questions. The questionnaire used was divided into two parts: one was filled by all adolescents and the other part specifically by adolescents who were or had ever been pregnant. The questions were in accordance to the objectives of this research; therefore, the questions were on adolescent knowledge on sex and its consequences, contraceptives, peer pressure in relation to sex and finally the role of gender in adolescent pregnancies. The main purpose of all the questions was to provide in-depth knowledge through views/opinions that are related to the problem of adolescent pregnancies in Kitui Township.

#### **3.6.2 Key Informant Guides**

Key Informant guides involved ‘qualitative in-depth interviews of people selected for their first-hand knowledge about a topic of interest. The interviews were loosely structured, relying on a list of issues to be discussed. Interviewers framed questions spontaneously, probed for information and took notes, which were elaborated later (USAID, 1996).

In this study, 10 key informants were selected to provide an in-depth narrative on adolescent pregnancies. Five teachers (3male and 2 females) were from Central Primary and five teachers (2 male and 3 females) from Muslim Secondary school.

Two of the teachers from each group were the respective head-teachers of the respective schools. In addition, different genders were selected to provide unbiased opinions when it comes to gender issues on the matter of adolescent pregnancies.

#### **3.6.3 Focus Group Discussions**

Focus Group Discussion is a technique where a researcher assembles a group of 8-12 individuals to discuss a specific topic, aiming to draw from complex personal experiences, beliefs, perceptions and attitudes of the participants through a moderated interaction (Hayward, Simpson and Wood, 2004). This study included eight focused group discussions

four from Central Primary whereby one encompassed the male students and the others, female students, only. This was meant to discourage shyness among the respondents. The same applied to Muslim Secondary school. The groups were made up of between 4-8 respondents all of the different ages randomly picked. Questions on adolescent pregnancies based on the objectives were used to stimulate discussions among these groups.

### **3.7 Secondary Data**

Available data from different sources were used to enrich the study. The secondary data was collected from different sources such as published journals and other articles, Ministry of Education from County archives, UN articles etc.

### **3.8 Data Analysis**

The quantitative data collected was analyzed using the statistical package for social science (SPSS) version 22. Quantitative data analysis involved deriving the descriptive statistics that entailed univariate (table of frequencies) and bivariate analysis (associations). Descriptive statistics simplifies the data collected into simple patterns and summaries that make it easier for the researcher to conclude (Rubin and Babbie, 2007, Creswell, 1994).

Categorical variables were described using actual numbers and percentages. Bivariate analysis was done to assess the association between different explanatory (independent variables and outcome (dependent) variables.

Qualitative data from the focus group discussions and interviews of key informants were transcribed, translated and analyzed thematically. The transcripts were read several times to identify themes and categories. A coding frame (codebook) was developed to facilitate the coding of transcripts using inductive coding. Data coding involves generating numerous category codes without limiting the number of codes used (Charmaz, 2006). The codes were grouped into categories to generate themes based on interpreting the underlying meaning of categories. The qualitative data will be presented through verbatim quotes. In the main, quantitative and qualitative data was integrated during analysis to generate a coherent story and presented alongside each other in the write-up.

### **3.9 Ethical Issues**

Ethics simply denotes what is morally right and wrong and the researcher must consider the ethical implications in research before commencing the research especially in regards to data collection. Hammersley and Traianou (2012) hold that qualitative study has more ethical implications compared to quantitative research as they collect data directly from the respondents which call for utmost privacy and integrity. Quantitative data is normally readily available reducing the ethical implications. *The information sought from the respondents will be used solely for the aim of this research and will be held with a high level of confidentiality and integrity.*

## CHAPTER FOUR

### 4.0 RESEARCH RESULTS

#### 4.1 Introduction

This chapter presents study findings and their discussion. The data has been organized into themes and sub-themes and discussed according to the study objectives. The thematic subsections covered under this study include: the effect of inadequate knowledge on adolescent pregnancies among students in Kitui township sub-Location Kitui County; The contribution of peer pressure to adolescent pregnancies; The extent to which social opposition to the provision of sexual and reproductive health information and services contribute to adolescent pregnancies; The gender ideology in sexual and reproductive health versus adolescent pregnancies in Kitui Township, Kitui County.

#### 4.2 Demographical Information of Respondents.

The respondents' profile information considered in this section included religious affiliation, age of the learner and teacher, gender and grade of the learner. Such information gave an better understanding of the interrelationship of the variables of the study. Table 4.1 gives summarizes the biodata of the learners' respondents while Table 4.2 gives geographic information of teachers' respondents.

**Table 4.1: Demographic characteristics of the learner participants**

Category		Frequency	Percent
Gender	Male	32	23
	Female	108	77
Age group	10 – 14	51	36
	15-19	84	60
	20 years and above	5	4
Religious Affiliation	Protestants	61	44
	Catholics	41	29
	Muslims	38	27
Education level	Primary	60	43
	Secondary	80	57

**Source: Field survey data (2020)**

**Table 4.2: Demographic characteristics of the teachers' participants**

Category		Frequency	Percent
Gender	Male	5	50
	Female	5	50
Age group	25-34	3	30
	35-44	3	30
	45 years and above	4	40
Religious Affiliation	Protestants	4	40
	Catholics	3	30
	Muslims	3	30
Education level	Diploma	3	30
	Degree	7	70

**Source: Field survey data (2020)**

This study entailed 150 participants enumerated randomly. Adolescent participants involved in the study were 140 (93%) as they were the center of interest. Further, 10 (7%) teachers purposively selected participated in the study as key informants who further shed more light on some variables of the study. Out of 140 interviewees, 108 (77%) were adolescent girls who filled questionnaires while 32 (23%) were adolescent boys who participated in focused group discussion. More girls were randomly enumerated to participate in the study than boys did because the theme of the study focusses more on them. The adolescent girls constituting 64 (59%) and 44 (41%) of the total girls population was drawn from Muslim Secondary School and Kitui Central Primary School respectively.

The data analysis was also segregated according to the age groups of the participants. The age as variable of the study was important as pregnancies were dependent on sexual maturity which was dependent on age. Girls with the age of 9 years and below were not as vulnerable to pregnancies as teenage were. The learners were grouped into three age groups of (10-14), (15-19), and (20-24) which contributed 51(36%), 84 (60%) and 5(4%) respectively. The age of the teachers who participated in the study ranged from 25 – 57 years. Gender wise, 5 male and 5 female teachers participated in the study.



Majority of the respondents from primary level who had attained the target age of the study sample were in class 8 while only a few were from class 7 and 6. The total respondents from primary school constituted 60 (43%). 80 (57%) of the respondents were from secondary school with 42 (53%) of the participants from secondary from form 2 and 4. All the sampled teachers had at least attained the diploma qualifications. The adolescent practices may differ with the religious affiliation. The data learner participants were further grouped into Protestants, Catholics and Muslims and their tallies were 60 (44%), 41 (29%) and 38 (27%) respectively. Religious aspect was considered a variable because it had an influence on social norms and beliefs which influenced sexual reproductive health. Similarly, teacher's religious affiliations were 40%, 30% and 30%.

#### **4.3 Status of Adolescent Pregnancies among School Going Girls Kitui Township Sub-Location**

The 108 female respondents were first asked whether they have ever been pregnant and the tallies are displayed in Table 4.3. The results show that only 5 (4%) of the adolescent learners had once been pregnant. 103 (96%) of the teenagers have had never been pregnant but had some information on adolescent pregnancies. A larger girl's population in secondary school were on family planning which could have led to lower cases of adolescent pregnancies.

**Table 4.3: Status of Adolescent pregnancies**

<b>Teenage pregnancies</b>	<b>Frequency</b>	<b>Percentage</b>
Ever been pregnant	5	4
Never been pregnant	103	96
<b>Total</b>		

**Source: Field survey data**

The findings were further confirmed by an adolescent's discussant who narrated that:  
*It is better to be on family planning than to carry out an abortion or withstand the shame and stigma of giving birth before completing school. It is shameful to visit clinic with*

*mothers while you are still a student. I better use all the family planning methods to ensure that I don't bring shame to my parents.*

Another female discussant, who is a teacher, revealed that;

*Yes, we have had reported cases of adolescent pregnancies from students. Currently, the numbers have dropped from let's say five to ten years back, which is a good thing.*

#### **4.3.1: Effects of Inadequate Sexual and Reproductive Health Knowledge to adolescent pregnancies among school going girls in Kitui township sub-location**

This section outlines the effects of inadequate sexual and reproductive health knowledge and how it contributes to adolescent pregnancies among school going girls in Kitui township sub location. The subsection describes the results on the influence and contribution of Parents, Teachers, Media and Doctors to sexual and reproductive health among teenagers. Also includes age and religion aspects.

The respondents were asked to state their sources of sexual and reproductive health knowledge in dealing with adolescent pregnancies and also their expectations on the same.

**Table 4.4: Source of Sexual and Reproductive Health knowledge among adolescents**

<b>Source</b>	<b>Frequency</b>	<b>Percentage (%)</b>	<b>Expectation (%)</b>	
Parents	32	23.08	60	
Teachers	86	61.54	25	
Media	13	8.85	5	
Doctors	9	6.53	10	
<b>Total</b>	<b>140</b>	<b>100</b>	<b>100</b>	<b>140</b>

**Source: Field Survey Data**

The largest source of SRH knowledge among the respondents were teachers at 61.54%. Parents came in second at 23.08%. This is contrary to the expectations of majority of the respondents (60%) who felt that parents should be the main source of sexual and

reproductive health knowledge as they are a child's first instructor. This was supported by a Key informant interviewee (teacher) who stated:

*“In the current society, the teacher spends more time with the child compared to the parent as opposed to the older generation where parents/relatives were the main source of instruction on growth, maturity and reproduction. As teachers, since SRH information is now part of the syllabus, it becomes easier to talk and share knowledge on reproductive health. This greatly dissolves the issue of shyness on the topic. As a result, the main knowledge of SRH becomes teachers.”*

In addition, a teenage girl in one of the focused group discussions stated:

*“It is quite embarrassing for us to us to ask some of these questions to our parents. This is because parents automatically conclude that you are interested, planning or even actively having sexual relations. As a result, you may get scolded or even punished just for bringing up the subject. Therefore, we tend to avoid or wait until the topic comes up, which usually happens in school.”*

The Media and Doctors also play a role as sources of SRH knowledge at 8.85% and 6.54% respectively. This is contrary to expectations where doctors should be at the forefront in impacting this information as they are more knowledgeable on matters reproductive health. This can be attributed to the change in society's behavior where media especially social media has become a major source of information among the youth, with google and Youtube being major contributing tools.

This was supported by a key informant who stated;

*“Nowadays, Social-media has become a key player in impacting knowledge as majority of students have access to these tools including tvs, computers, phones etc. We cannot fight the change in our society but we try our best to provide guidance in the utilization and access of these tools in terms of emphasizing on age limits and also reducing the screen time so as to avoid cultivation of vices such as addiction.*

#### 4.3.1.1: Age of the respondents and Knowledge on Sexual and Reproductive Health Influence on Adolescent Pregnancies

The study investigated whether the age of the respondent determined the extent of knowledge on sexual and reproductive health and its impact on the adolescent pregnancies in Kitui Township sub-Location. Direct proportionality was noted between the age and the accurate knowledge. 60 (71%) of 84 adolescent learners between the age of (15-19) which was higher than 59% of the tallies from the age group of (10-14) years. Five (5) adolescent learners interviewed and whose age surpassed 20 years had proper knowledge on sexual and reproductive health. The findings of gender on knowledge of sexual and reproductive health are presented by table 4.5.

**Table 4.5: Gender on sexual and reproductive health knowledge**

Age group	Frequency	
	Girls	Boys
10-14	33	18
15-19	84	12
20 years and above	3	2

**Source: Field survey data**

Further examination of the results reveal that adolescent girls had accurate information as compared to the boy's counterparts. A girl respondent whose age lies between (15-19) years confirmed during focused group discussion that they are given sexual and reproductive health information by teachers;

*"We usually have separate classes on reproductive health by our teachers where we are refreshed monthly on sexual reproduction. On this special meeting, we are free to ask questions without any shame over when we are in a class where boys laugh at us making us feel shy. We also share talks more class 8 girls."*

#### **4.3.1.2: Religious Affiliation of the Respondents and Knowledge on Sexual and Reproductive Health Influence on Adolescent Pregnancies**

Religious segregation had an effect on the extent of knowledge on sexual and reproductive health and how it has influenced the adolescent pregnancies in Kitui township sub-Location. Table 4.7 presents various religions and the percentages of respondents with accurate knowledge.

**Table 4.6 Religious Affiliation of the Respondents and Knowledge on Sexual and Reproductive Health Influence on Adolescent Pregnancies**

<b>Religion</b>	<b>Frequency</b>	<b>Percent</b>
Protestant 61	61	44
Catholic 41	41	29
Muslim 38	38	27

**Source: Field survey data**

The adolescent discussant reported that, they are sensitized on the subject during religious camps. 36 (59%) of the protestants were knowledgeable. Over 80% of the knowledgeable Protestants were adolescent girls. Adolescent girlss were ignorant even though socially societal setup has sidelined them as far as this matter is concerned. 18 (44%) of catholic faithful were knowledgeable and they learnt from their church during youth meetings after sermon.57% (22) of adolescent Muslim girls discussant disclosed they usually undergo teachings by their elders on sexual reproductive health and adolescent pregnancies.

#### **4.3.2: Contribution of Peer Pressure to Adolescent pregnancies.**

The selection illustrates how peer pressure affects the levels of adolescent pregnancies in Kitui Township, Kitui County. The interviewees were asked whether they are sexually active. Response was as follows;

**Table 4.7: Sexual activity among respondents**

SEXUALLY ACTIVE	YES		NO	
	Frequency	Percentage	Frequency	Percentage
Age-group				
10-14	16	31.4	35	68.6
15-19	62	73.3	22	26.2
20 above	4	80.0	1	20.0
<b>Total (140)</b>	<b>82</b>		<b>58</b>	

**Source: Field Data Survey**

From the table above, the largest sample of sexually active interviewees was from age-group 15-19 at 62%.

Second question was whether being sexually active was a result of peer pressure or other factors. Responses was as follows;

**Table 4.8: Peer pressure among respondents**

	PEER PRESSURE		OTHER FACTORS	
	Frequency	Percentage	Frequency	Percentage
Age-group				
10-14	13	81.3	3	18.7
15-19	56	90.3	6	9.7
20 above	1	25.0	3	75.0
<b>Total (82)</b>	<b>70</b>		<b>12</b>	

**Source: Field Data Survey**

From the above table the largest sample group to be affected by peer pressure on matters sex, was also age-group 15-19 at 90.3%.

These statistics were supported by responses from the discussions. In the Focus Group discussion one boy said,

*“Of cos the topic of sex always comes up in one way or the other. Everybody always talks about their experience. Hardly will you hear somebody say they have never experienced it.*

*This causes somebody to be curious and therefore try. Speaking from experience makes you feel like you belong.”*

A female discussant also contributed by saying:

*“When you see your friends coupled up and all they talk about is my boyfriend did this or my boyfriend did that, you are more open to the idea of having a boyfriend. Generally, it becomes easier to give into those feelings and also act on them just because everyone else is doing it.”*

One of the Key informants who is also an administrator had this to say:

*“We face a lot of disciplinary issues especially from the 15-19 age-group on matters relating to sex. We do not encourage these opposite sex relationships as they come with a lot of consequences such as pregnancies, distractions from school-work, depressed emotions and the likes. Most of the students’ mention friends as the root cause of their indulgence in the first place. We provide lectures and counsel against these relationships but at the end of the day we cannot police the students everywhere, there is only so much which we can do”*

### **4.3.3: Contribution of Social Opposition to Social and Reproductive Health**

#### **Knowledge and services to Adolescent pregnancies.**

The interviewees (82 sexually active) were asked whether they are able to access contraceptives. Results are summarized in the table below:

**Table 4.9: Access to contraceptives by girls**

Access contraceptives	YES		NO	
	Frequency	Percentage	Frequency	Percentage
10-14	0	0	16	100
15-19	21	34	41	66
20 above	2	50	2	50
<b>Total 82</b>	<b>23</b>	<b>28</b>	<b>59</b>	<b>72</b>

**Source: Field Data Survey**

From the survey 28% of the girls respondents stated that the main source of contraception they have access to, is the free condoms supplied by the government.

From the table majority 72% have no access to SRHK and contraception.

A girl from age group 10-14 stated that:

*“We cannot afford these contraceptives as we depend on our parents wholly. At the same time one cannot go ask for money to buy such as this will end up in disciplinary issues, since we are not supposed to be engaging in sexual encounters in the first place.”*

One of the older boys in group 15-19 stated that:

*“In as much as the government issues these condoms they are never enough as they are not stocked frequently. More often they run out and it takes a while for restocking. This causes the numbers of unprotected sex to increase hence adolescent pregnancies.”*

#### **4.3.4: Contribution of Gender Ideology to Adolescent pregnancies.**

The interviewees (150) were asked whether Gender Ideology affects adolescent pregnancies. Responses are summarized in the table below.

**Table 4.10: Effect of Gender Ideology to adolescent pregnancies**

Age-group	YES		NO	
	Frequency	Percentage	Frequency	Percentage
10-14	34	67	17	33
15-19	71	86	13	14
20 and above	15	100	0	0
<b>Total (150)</b>	<b>120</b>		<b>30</b>	

**Source: Field Data Survey 2020**

From the above table, majority of the interviewees thought that gender ideology contributes to adolescent pregnancies.

A key informant in the survey supported the statistics above by saying:

*“This is one of the major problems we encounter as teachers when teaching on sexual and reproductive health. Majority of the students are socialized in a way that talking about sex*



*is almost a taboo. At home they hardly talk about these things with their parents and if so, it's usually left to the mother. The mother finds it difficult to talk to the boys about sex and vice versa. The children in the long run grow up knowing responsibilities arising from sex belong to the woman. It is the responsibility of the girl to take care of her body. If in the case the girl is not aware about contraceptives or has no access to them, pregnancy cases rise significantly."*

One of the girls in the group discussions supported the statistics by saying:

*"In our patriarchal societies girls are deemed the weaker sex. Therefore, forcing your boyfriend to use the most easily accessible and also cheaper contraceptives like condoms is difficult. If he doesn't want to it is almost impossible to force him. Once they impregnate a girl they move on so easily to the next girl since they do not have to deal with the consequences of carrying the pregnancy."*

## **CHAPTER FIVE**

### **5.0 DISCUSSION AND INTERPRETATION OF THE RESEARCH FINDINGS**

#### **5.1 Introduction**

This chapter presents the discussion and interpretation of research findings based on the research objectives. The discussion is organized around subsections that align with the research objective. The discussion starts with a summary of findings by subsection and how the findings relate with other studies and what these findings mean. The study sought to investigate the factors influencing adolescent pregnancies among school-going girls in Kitui Township sub-Location, Kitui County, Kenya.

#### **5.2 Summary of the Findings by the Objectives**

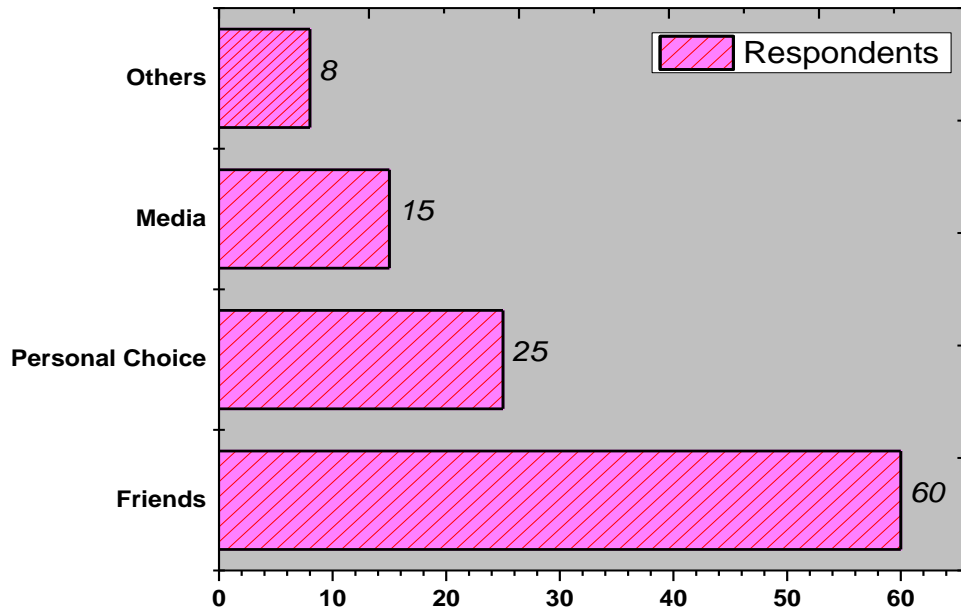
The objective of the study was to investigate the factors influencing adolescent pregnancies among school-going girls in Kitui Township sub-location, Kitui County. To actualize the general objective, the research employed several specific objectives as follows: To investigate the extent to which inadequate sexual and reproductive health knowledge contributes to adolescent pregnancies. To examine the extent to which peer pressure contributes to adolescent pregnancies, to determine the extent to which social opposition to the provision of sexual and reproductive health information and services contribute to adolescent pregnancies, to determine how gender ideology in sexual and reproductive health affects adolescent pregnancies in Kitui Township, Kitui County.

##### **5.2.1 Sexual and Reproductive Health Knowledge Contributions to Adolescent Pregnancies among Students**

The study sought to establish the extent to which inadequate sexual and reproductive health knowledge contributes to adolescent pregnancies among adolescents within an age of 13-19 years. The reported cases and data on teenage pregnancies was provided by the key informant. Upon interrogation of girls' gender, over 66% expected teachers to guide them on matters of sexuality. The information collected via an individualized questionnaire filled by teenage girl's reports that they have attained sexually active age and are mature for reproduction. Over 50 % of girls had boyfriends and further revealed it was their personal

choice to have them. They felt comfortable in a relationship as they felt is a sign of endowment with beauty.

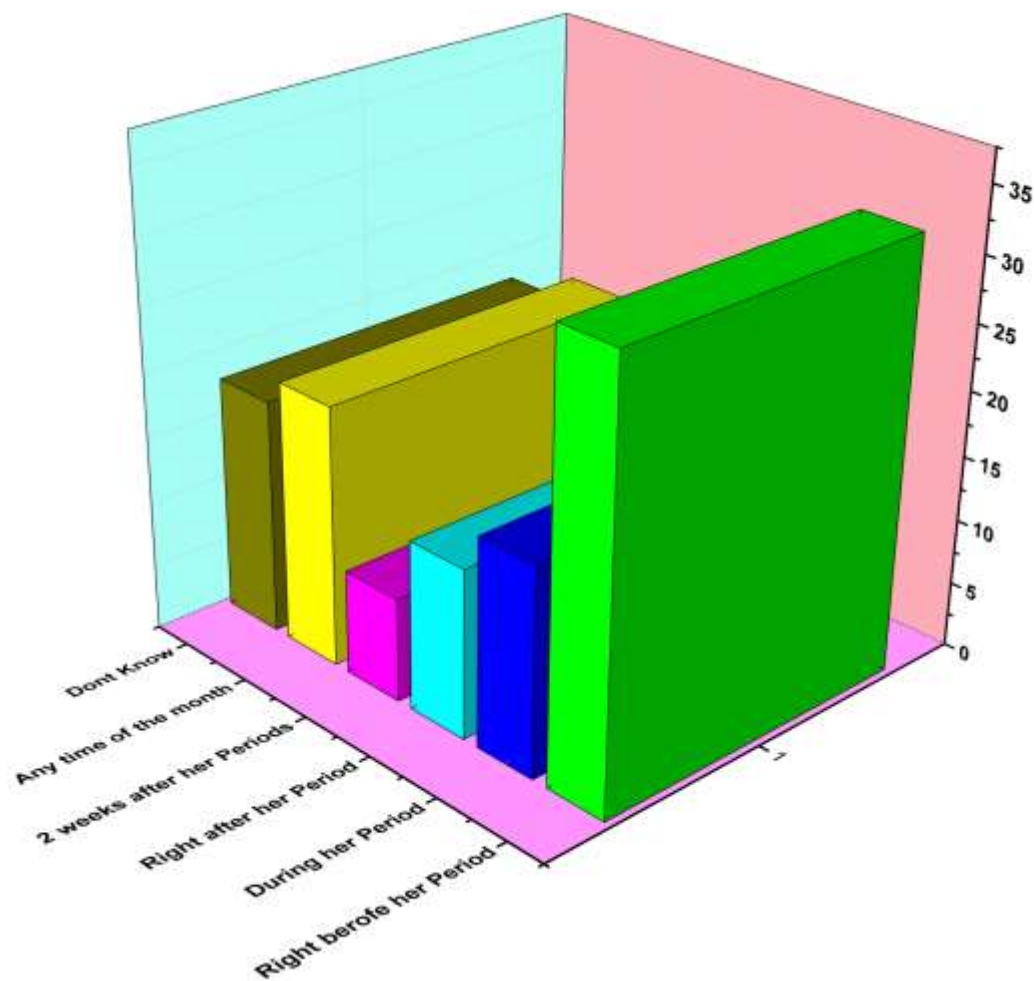
Figure 5.1 is a bar graph showing statistics collected using an individualized questionnaire filled by girls only on who encouraged them to have a boyfriend.



**Figure 5.1: Source of influence to school going girls dating**

Teenager constituting over 55% (60) of the total population revealed that they were encouraged by their friends (peers) to own boyfriends secretly. Those who did not have a boyfriend were mocked and sidelined by close girls' friends. 23% of the girl's sample reported it was their choice to have boyfriends. Media contributed 14% to girls dating boyfriends and others factors that led to some dating not mentioned in the questionnaire contributed to 8%. This shows that peer influence is high and there is a need for intensifying the guidance and counselling services in the schools to reduce the effect of peer influence. There is also a need to limit teen's access to media like phones, and some TV programs as some cited that they saw intimacy for the first time on television and decided to follow as it looked enticing to them. Mobile phones were reported as a key propellant to ease of

communication and meeting of adolescents. There is thus a need to educate school-going teenagers on the correct use of phones to avoid misuse in case we cannot confiscate or deny them the phone completely. There is a need to regulate its use. Over 32% of the girls with boyfriends indicated that they indulge in sexual behaviors with them some for pleasure and another moneymaking as reported by subthemes from focused group discussions. Others have had sex for exploration to quench curiosity and confirm views from their peers. Figure 4.3 is a comparative bar graph drawn from data collected using the questionnaire tool on when a girl/woman is likely to get pregnant and the following were the responses.



**Figure 5.2 Girls knowledge on menstrual fertility periods**

Figure 5.2 above reveals that over 33 (31%) of the total sample of 108 girls interviewed knew that one is likely to get pregnant when she engages herself in unprotected sex right

before her period. 15% of the girls had information that when one engages in sex during her menses, she is likely to get pregnant. A sample representing 12 % reported that one is fertile right after her period. Only 7 % reported that one is likely to become pregnant 2 weeks after her periods. A sample representing 19% thought that any time of the month one could become pregnant if sex is done without protection and 17% had no information concerning the subject. This blend of information was availed to teenagers from a variety of sources some with intentional bias. For the case of one is fertile at any time of the month was mostly reported to be from their caregiver and possibly was meant to discourage them from pre-marital sex. This diversity in views suggests that the teenagers have no accurate information on the fertile days and this increases teenage pregnancies in the area.

These research findings are in line with Muganda Onyando and Omondi (2008) who established that there was need for introduction of comprehensive sexuality education in schools. In addition, Collins, Allagiri and Summers (2002), also agree that students who are sexually active should be provided with information that they need so that they can protect themselves.

### **5.2.2 Peer Pressure Contributions to Adolescent Pregnancies**

The role of peers as agents of socialism and their potential of having dicey impacts on the lifestyle of teenagers especially in the area of sexuality was investigated. The quantitative analyses report 10% influence contribution of peer pressure on decisions by teenagers to own a boyfriend to conform to the norms on sexual behavior to remain relevant to the peer group he or she belongs.

Ultimately, the effect of peer pressure was significant for the surveyed sample. The findings are in concurrence with data published by Klein 2005 & Kukln 2008 which states that; the possibility of peers influence one's behavior is central to the most important policy issues in our societal context.

Earlier related researches reveal that most teenagers' misconduct occurs in groups. A survey on sexual behavior among youths in Africa and America showed peers norms were

the greatest influence on sexual conducts among those who had not discussed with their parents the use of contraceptives particularly condoms.

### 5.2.3 Contribution of Social Opposition to SRH Knowledge and Contraceptives to Adolescent Pregnancies.

The current sample of the teenagers in many themes had significant influence by peers. On matters of use of contraceptives, the statistical tallies for various sources of information reports friends as the highest source of contraceptives. Before the parent gave them an idea on contraceptives, already their peers had shed light on the same.

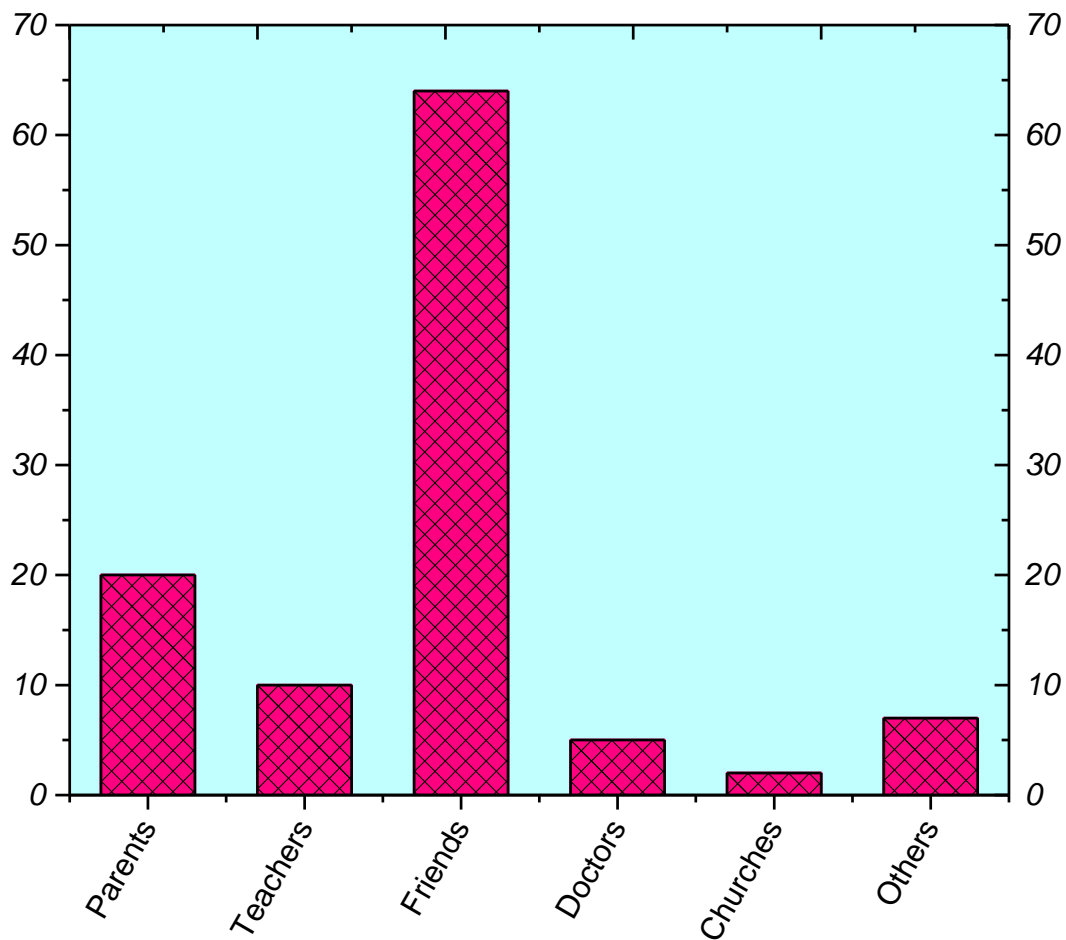


Figure 5.3: Bar graph on knowledge on contraceptives

The highest tallies on how information on contraceptives reached the teenagers were reported to be from teenage friends. When teenagers are seeking preventive measures on teenage pregnancies are also given ways of preventing teenage pregnancies. Over 50% of the teenage pregnancies in primary and secondary school knew the way of preventing teenage pregnancies. 19 %, ha some information shed to them by their mothers and fathers. For form three, they had information on contraceptives from teaches which was attributed to coverage of chapter on biology by in form three by teachers. Health care providers and churches had insignificant input in terms of dissemination of knowledge on contraceptives. The study concludes that peer pressure has an eminent influence on typical teenager's view on sexuality. Teenagers tend to conform to the norms on sexual behaviors deemed acceptable to the peer grouping they belong. Therefore, there is a need for caregivers to ensure that the agents of socialization to their school-going teenagers are morally upright and whatever they feed to their children meet the societal norm. The extracts of the questionnaire show that most interactions take place in the gatherings of worship and learning institutions as are the places where teens spend most of their time discussing freely their issues. The attendants to teenagers in the said places need to constantly guide the learners on the matters of sexuality.

#### **5.2.4 Contributions of Gender Ideology to Adolescent Pregnancies**

Gender norms and attitudes - Gender norms include female gender deferring some decisions in favour of men. Men dominate decision making in the studied context and girls are not supposed to be taught some things. For example, the use of contraceptives among girls in some cases had parental approval more so motherly who approves it without fathers consent. Due to such fears embedded in their cultural norms, parents are major determinants of contraceptives use. Consequently, mothers loyal to their husbands cannot approve of the use of contraceptives and as a result, their teenage girls get pregnant.

Cultural notions and taboos- The cultural beliefs of the studied area bars teenage girls and women from accessing and using some form of protection like condoms. They believe good girls and women should not buy some contraceptives like condoms as it brings embarrassment and fear of being gossiped. Men are given sexual autonomy as long as they

are of age but the female gender should remain passive and inexperienced before marriage. The findings further revealed that Virginity was prized for unmarried women and thus girls should maintain their purity in the context of sexual matters. This factor has bars girls from access to contraceptives thus the moment they indulge in sexual activities they get pregnant. Teenage girls, in particular, reports fear of being noticed to be sexually active and thus disclosing their secrets and stance on the use of preventative measures on teenage pregnancies is minimal. Gender norms dictate that daughters, especially older daughters, should provide for the family. Women are expected to behave with propriety, including when they move away from home for work.

Cultural values, beliefs and taboos- cultural values relate to how one presents himself or herself in society. The teenage girls reported that their mothers mostly advised them not to bring shame into their family by abstaining from sexual and reproductive health behaviour and outcomes. Some teens feared their fathers mostly but reported that they used natural counting methods to determine their safe days.



## **CHAPTER SIX**

### **6.0 CONCLUSION AND RECOMMENDATIONS**

#### **6.1 Introduction**

This chapter gives an overview of the conclusion of the study. It also provides recommendations that pave way for further research and policy implications.

#### **6.2 Conclusion**

The study was carried out as proposed. The questionnaires, Key informant guides and focused group discussions were used as data collection tools. The study sought to assess social-cultural factors influencing adolescent pregnancies among school going girls in Kitui township sub-location, Kitui County, in Kenya. The data was collected according to proposed themes and sub themes. The data was keyed in SPSS and analyzed thematically. The findings reveal that knowledge on sexual and reproductive health was low, which was linked to rising cases of pregnancies in Kitui Central Township Sub-Location. It is the responsibility of all stakeholders involved in the lives of children to impact this sexual and reproductive health and this includes parents, teachers, health providers and the media. Active participation of the stakeholders will significantly reduce adolescent pregnancies in the area.

Peer pressure was also blamed for poor decision by teenagers more so on choices made by teenage girls. The choices on whether to have boyfriend or to access and use contraceptives were majorly influenced by peers. As a result, adolescents should be better equipped with tools on how to deal with pressure from their peers in their daily lives.

Social opposition to provision of sexual and reproductive health was also blamed for contributing to cases of adolescents, pregnancies. As mentioned above it is high time the society accepts change and easily avail all resources to the curious adolescents in order to curb the problem of teenage pregnancies.

Gender norms, cultural notions and cultural values were also blamed for denying school going teenagers' access to family planning information. The parents should revise and

community educated on the importance of contraception among adolescents. This is possible through dispensing SRH knowledge through societal groupings.

The overall conclusion from the study is that adolescent girls Kitui township are faced by constellation of forces ranging from individual, school, community and society that expose them to the risk of getting pregnant. Therefore, interventions to address adolescent pregnancy should be multi-layered ranging addressing individual (knowledge on SRH), socio-cultural and urban context (peer pressure, social opposition to FP use and societal and gender norms).

*. Based on the result of this study, the following conclusions were made: - The head teachers, teacher counsellors and students consented that, media influence, peer influence, low self-esteem as well as negligence of parents, dating early and broken relationships as the social causes of girls pregnancies in secondary school in the area of study.*

### **6.3 Recommendations.**

The study recommends the following;

1. This study recommends implementation of age specific sexuality and health education in schools. This should ensure among other things, inclusion of information on adolescent health and social challenges in the current syllabus.
2. Parents needs to rise against societal norms and educate their girls on how to overcome teenage challenges.
3. A further study on non-school going adolescent is needed with the age gap as low as 10 years.

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## APPENDICES

### Appendix 1: Study Questionnaire

A. Social and Demographic Information.

1. Sex

Male[  ]                      2. Female [  ]

2. Age..... years

3. Level of Education

- 1.[  ]None
- 2.[  ]Primary level
- 3.[  ]Secondary Level
- 4.[  ]College Level

4. Religion

- 1.[  ]Christian
- 2.[  ]Muslim
- 3.[  ]Hindu
- 4.[  ]Others (please specify).....

5. Do you have a boyfriend/girlfriend? 1.Yes (  ) 2.No (  )

6. Which of these reasons encouraged you to get a girlfriend/boyfriend? TICK appropriate

	Friends	
	Personal choice	
	Media	
	Other (specify)	

7. Which among the following periods do you think a girl/woman is most likely to get pregnant?

	Right before her period	
	During her period	
	Right after her period	
	2 weeks after beginning of period	
	Anytime of the month	
	Don't Know	

8. Who taught you about sex/contraceptives? TICK

	Mother./Father	
	School teacher	
	Friend	
	Doctor	
	Church	
	OTHER (specify)	

9. From whom did you EXPECT to learn about sex/contaceptives?

	Mother. /Father	
	School teacher	
	Friend	
	Doctor	
	Church	
	OTHER (specify)	

10. Are you sexually active      1. Yes ( )      2.No ( )

11. At what age did you first become sexually active? ..... years

12. Do you know of any method (contraceptive) you can use to prevent pregnancy?

1. Yes ( )   2.No ( ) If YES name the method.....

13. How old were you when you first heard of these methods? State age..... Years

14. Who among the following has talked to you about ways of avoiding unwanted pregnancies?

TICK appropriate box

	Mother/ Father	
	Teacher	
	Friend	
	Doctor/ Health official	
	Church	
	Other (specify)	



15. Are you aware of free contraceptive services available in Government hospitals/Schools?

1.Yes ( ) 2.No ( )

16. Have you ever obtained any form of contraceptive from any clinic/hospital/chemist?

1.Yes ( )2.No ( )If answer is NO SKIP question 13

17. What contraceptive have/do you use? TICK appropriate

	Oral contraceptive (pill)	
	Diaphragm	
	Intrauterine device (IUD)	
	Natural (counting safe days)	
	Withdrawal	
	Other(specify)	
	None	

18. Why don't you use contraceptives? TICK appropriate

	Don't know about contraceptives	
	Fear using them because of body safety	
	Partner refused	
	Unavailability (unassecebility)	
	Unnecessary	
	Hospital staff refused	
	Religious beliefs	
	Finances (affordability)	
	Other (specify)	

19. Are you/ ever been pregnant 1.Yes ( ) 2.No ( )

20. If your answer is **YES** proceed to part B

If **No** proceed to C

B. Extent to which Inadequate Sexual Knowledge Contributes to Adolescent Pregnancies in Kitui Township. *(TO BE FILLED BY PREGNANT TEENS)*

21. How did you find out you were pregnant? Explain.....

22. At what age did you first conceive?.....years

23. Did you desire to be pregnant? Yes ( ) No ( )

24. Whom were you living with when you first got pregnant? TICK

	Father and mother	
	Father only	
	Mother only	
	Relatives	
	Friends	
	Alone	
	Other (specify)	

25. Have any of your friends been pregnant?

1. Yes ( ) 2.No ( )

26. If YES did they get pregnant before or after you?.....

27. What was your response to getting pregnant? TICK

	Marriage	
	Abortion	
	Attempted abortion	
	Other (specify)	

b) I knew about the changes that occur to my body during adolescence.

1. Yes ( ) 2. No ( )

c) I had a discussion with my parents / care givers about sex before I got pregnant

1. Yes ( ) 2. No ( )

d) I knew about abstinence before I got pregnant

1. Yes ( ) 2.No ( )

e) I had knowledge about contraceptives before I got pregnant

1.Yes ( ) 2.No ( )

f) I had access to contraceptives before I got pregnant

1.Yes ( ) 2. No ( )

g) I did not know about the dangers of unprotected sex before I got pregnant

1. Yes ( )

2. No ( )

h) I got pregnant by (Tick the appropriate box)

Known Person		Unknown Person	
Boyfriend –agemate (within 5years)		Relative	
Boyfriend – older (by more than 15 years)		Leader/ Mentor (teacher,pastor, etc..)	
		Stranger	

i) According to you who do you think should be responsible for avoiding unwanted pregnancies?

- a) Boy/Man
- b) Girl/Woman
- c) BOTH

j) According to you who should be blamed when girls get pregnant while still in school? Give reasons for your answer.....

.....

.....

k) In my opinion, the following should be done so as to reduce the problem of adolescent pregnancies among school going girls in Kitui Township.....

.....

.....

**Appendix II: Key Informant Interview Questionnaire.**

A. Social and Demographic Information.

1. Sex.

1. Male ( ) 2. Female ( )

2. Age.....years

3. Institution..... Position.....

4. How many pregnant girls aged between 13-18 years are you personally aware of?.....

5. Could you kindly assist me with their contact information?

Name (if aware):.....

Address (if aware) .....

6. What in your opinion is the biggest contributor of unwanted pregnancies in Kitui Township? Explain.....

.....

7. In your opinion how does peer pressure among adolescents affect unwanted pregnancies and what can be done to solve the issue?.....

.....

8. Do you think contraceptives should be availed to students?

1. Yes ( )

2. No ( )

If YES, Please explain your answer

.....

9. What in your opinion is the biggest hinderance to use of contraceptives in the region by adolescents?

.....

10. Please explain the agents of social opposition to contraceptive use in this region?

.....  
.....  
.....  
.....

11. Do you support introduction of comprehensive sexuality education in schools?

.....

Please explain your answer

.....  
.....  
.....

12. What would be your recommendations on the methods that can be used to reduce adolescent pregnancies in KituiTownship?.....

.....  
.....

### **Appendix III: Focus Group Discussion**

- (i) What is the role of sex among boys and girls or partners?
- (ii) Have you ever had sex? Who introduced you to your first sexual experience? (probe: boyfriend/girlfriend, peers, media, partner, teacher,e.tc), what were circumstances of first sex( venue, motivations)
- (iii) Whose responsibility is it to equip adolescents with Sexual and Reproductive Health Knowledge? And what can be done to ensure this is carried out?
- (iv) How to view the problem of adolescent pregnancy in this region?
- (v) How does peer pressure contribute to increased cases of unwanted adolescent pregnancies and what can be done to curb this?
- (vi) What are the biggest hinderances to accessibility of contraceptives and what can be done to solve this issue?
- (vii) How does gender relate to cases of adolescent pregnancies?