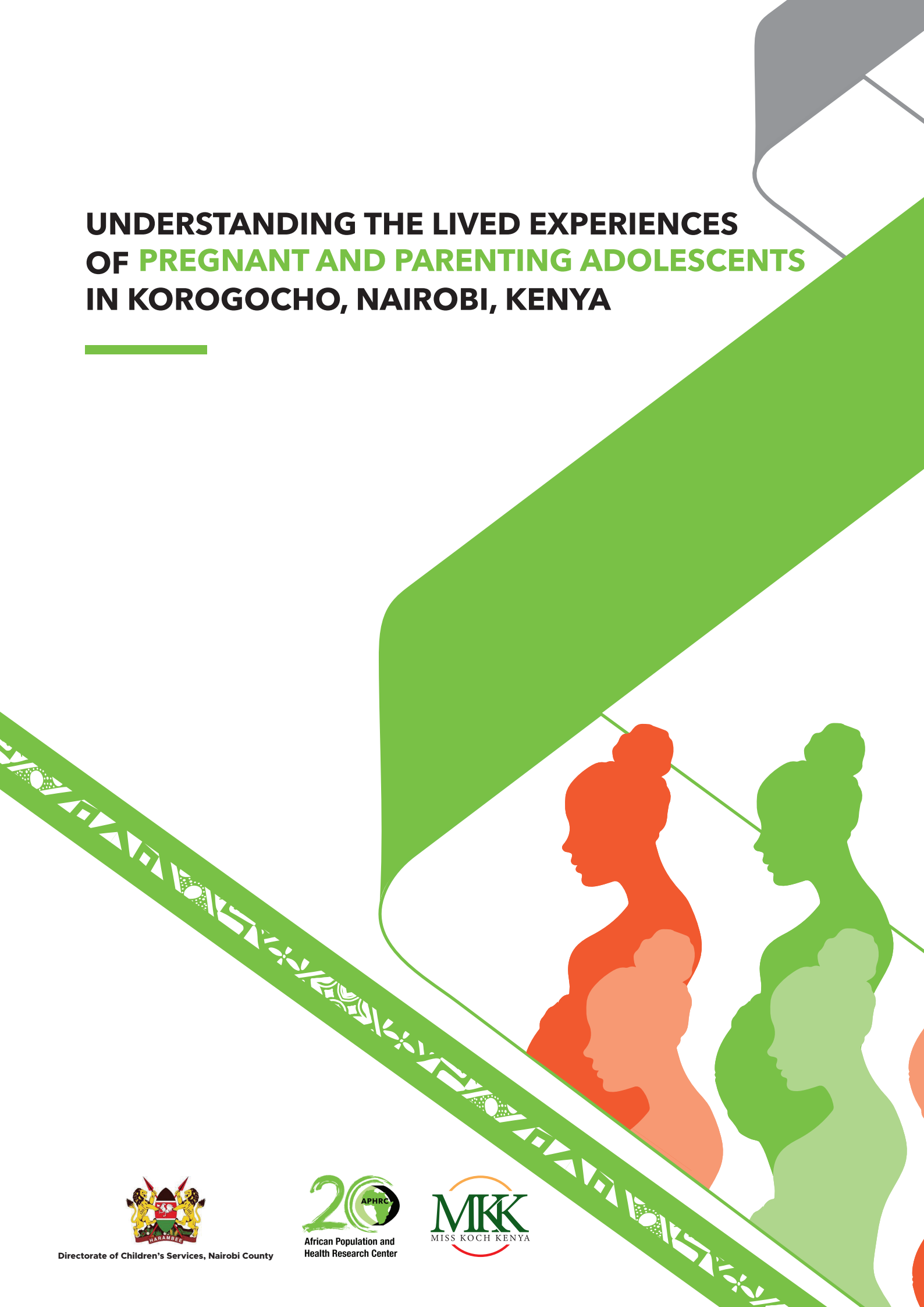
UNDERSTANDING THE LIVED EXPERIENCES OF PREGNANT AND PARENTING ADOLESCENTS IN KOROGOCHO, NAIROBI, KENYA



Directorate of Children's Services, Nairobi County

African Population and Health Research Center

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ABREVIATIONS

APHRC	African Population and Health Research Center
COVID-19	Coronavirus disease 2019
HIV/AIDS	Human immunodeficiency virus / Acquired immunodeficiency syndrome
ID	Identity card
IDI	In-depth interview
IUD	Intrauterine device
KII	Key informant interview
NUHDSS	Nairobi Urban Health and Demographic Surveillance System
PPA	Pregnant and parenting adolescent
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa

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EXECUTIVE SUMMARY

Background

While a constellation of governments, advocacy actors, researchers, and partners has focused their attention on reducing adolescent pregnancies, there is less focus on the well-being of pregnant and parenting adolescent girls in Africa. The need to develop programs and policies that support the empowerment of pregnant and parenting adolescents is paramount, given that millions of girls start childbearing in their adolescence in Africa, which puts them at significant risk of poor health, social, and economic outcomes. Such interventions must be guided by rigorous and contextually relevant evidence. Drawing on our experience of implementing lived experiences surveys among pregnant and parenting adolescents in Malawi and Burkina Faso as part of the Challenging the Politics of Social Exclusion project, the African Population and Health Research Center (APHRC), in partnership with Miss Koch Kenya and the Directorate of Children's Services, Nairobi County, conducted a mixed-methods study on the lived experiences of these pregnant and parenting adolescent girls in Korogocho, an informal settlement in Nairobi.

While a constellation of governments, advocacy actors, researchers, and partners has focused their attention on reducing adolescent pregnancies, there is less focus on the well-being of pregnant and parenting adolescent girls in Africa.

Study objectives

The objectives of the study were to:

a) Document the drivers of early pregnancy among adolescents aged 10 to 19 years
b) Describe pregnant and parenting adolescent girls' experiences in health facilities
c) Document the impacts of adolescent childbearing on the health and socioeconomic well-being of adolescents
d) Describe how adolescent girls and boys navigate motherhood and fatherhood, respectively
e) Assess the barriers to and facilitators of school re-entry
f) Explore possible interventions to improve pregnant and parenting adolescents' health and well-being

Methods

We adopted a concurrent equal status mixed-methods design, triangulating data from qualitative and quantitative approaches. Survey participants were selected using a two-stage stratified sampling approach. First, we conducted a household listing in all nine villages in Korogocho. In the second stage, all identified pregnant and parenting adolescent girls were recruited into the study. Purposive sampling was used to select the respondents for the qualitative study. Overall, a total of 594 girls took part in the survey. The qualitative study was conducted among parenting boys (n=10), pregnant and parenting girls (n=22), parents/guardians of adolescents (n=10), teachers (n=4), community leaders (n=3), health care providers (n=4), religious leaders (n=3), policymakers at the county government (n=3), and representatives of civil society organizations and non-governmental organizations (n=4).

Findings

The context of adolescent pregnancy

The majority of the pregnant and parenting adolescent girls (76.7%) reported having unintended pregnancies. Approximately 72% were single and 49% were still in school at the time they became pregnant for the first time. Most girls first had sex while still in school (73.7%), and 56.2% did not use condoms the first time they had sex. Factors associated with early and unintended pregnancy include curiosity about sex, poor contraceptive knowledge, ignorance, breakdown of families, family conflict, limited parental support, lack of provisioning and supervision, poverty, sexual violence, and COVID-19–related school closure.

Experiences at the health facility

A vast majority of girls accessed antenatal care services (92%). However, most initiated antenatal care late; consequently, only one in three of them (34.6%) completed four antenatal care visits, and approximately 3% completed eight visits. The in-depth interviews revealed that lack of support from parents/guardians, low knowledge of antenatal care, social stigma, isolation from community members, poverty, shame, ignorance, and fear of health care providers hinder girls from seeking antenatal care services early. About one in three girls reported mistreatment and abuse during delivery. Specifically, 23.9% of adolescent mothers were verbally abused, 6.2% were physically abused, and 14.3% were stigmatized or discriminated against. About one in 10 reported that they were detained for being unable to pay user fees.

Livelihood challenges

Upon delivery, adolescent mothers faced economic hardships, such as a lack of income to take care of themselves and their babies. Further, most adolescent mothers took up menial jobs, such as hand-washing clothes, and sex work to sustain themselves and their babies. Some adolescent mothers received material and financial support from their partners, who accepted childcare responsibility, whereas others received material support from community members.

Mental health status and exposure to violence

Early and unintended pregnancy exposed adolescent girls to social stigma and isolation, mental distress, and economic hardships: 40% reported mild depression symptoms, 35% minimal symptoms, and 25.3% moderate or severe symptoms. Common depression symptoms reported during the qualitative interviews were suicidal thoughts, self-harm, stress, worry, fear, shame, self-isolation, guilt, loss of appetite, and sadness. Despite the burden of mental distress, only a few girls received psychosocial supports from community-based organizations.

Close to half of the girls (48.8%) had experienced violence—physical, emotional, and sexual—from intimate and non-intimate partners. Girls were more likely to have experienced emotional violence (37.2%), followed by physical (27.4%) and sexual (20.8%) violence. Approximately 25% of the girls experienced intimate partner violence.

Childcare

About 74% of girls were somewhat or very worried about not being able to take care of their child, and 46% of adolescent mothers reported that they had no one to rely on. Girls reported that their mothers helped them with childcare mostly in the morning (85%) and at night (90%). However, girls themselves cared for their children during the day. The critical challenge that most girls faced was a lack of money and jobs. Because of the burden of childcare responsibilities and the unaffordability of daycare center fees, they were unable to work or return to school. Being unemployed meant they were unable to adequately provide for their babies' needs, including medicines, food, diapers, and clothes. Childcare responsibilities also restricted girls' movements and their ability to socialize with friends.

Barriers and facilitators of school re-entry

Only five girls had never attended school. About half of the rest dropped out of school due to unintended pregnancy. Approximately 91% of 589 girls who had attended school were out of school. Forty-two percent of out-of-school girls (n=535) desired to return to school but were unable to due to challenges such as lack of childcare support, financial constraints, parental opposition to schooling, and hostile school environments. The majority (79.3%) of adolescent mothers showed minimal interest in returning to their previous schools due to the fear of experiencing shame, stigmatization, and discrimination from students and teachers. Adolescent mothers identified the dire need for financial (96.9%) and childcare (51.1%) support, school necessities (39.2%), and guidance and counseling (10.1%) as the facilitators of school re-entry. Evidence from qualitative data revealed more facilitators of school re-entry: the desire for a better future, childcare and financial support, acceptance in school, breastfeeding breaks, a special school for adolescent mothers, and advice and encouragement.

Discussion

Early and unintended childbearing adversely affects adolescent girls in low-income informal settlements. Poverty, low contraceptive knowledge, family conflict, peer pressure, and lack of family support and supervision heightened their vulnerability to early and unintended pregnancy. Becoming pregnant so early hampered their educational dreams, with a vast majority of girls being out of school and lacking the support needed to return to school. The study findings highlight the need for greater support to pregnant and parenting adolescent girls to ensure their and their children's health and well-being.

Recommendations

The recommendations highlighted in this report were informed by discussions during a validation meeting held with community leaders, parents, policymakers, and pregnant and parenting adolescents.

Preventing early and unintended pregnancies

Early and unintended childbearing in urban informal settlements is fueled by factors at all socioecological levels: individual, family, community, and structural. Given the complexities of these factors, we recommend that governments and their partners develop comprehensive programs that address the multiple determinants of adolescent pregnancies, including alleviating poverty and ensuring that young people have access to accurate sexual and reproductive health information and services to prevent both early and unintended pregnancies and repeat pregnancies among adolescent parents.

Access to maternal health care

This study shows that a vast majority of adolescent girls received antenatal care services. However, only a few initiated antenatal care early or completed at least eight visits. Fear, shame, and stigma made girls conceal their pregnancy and reluctant to seek antenatal care services. During childbirth, girls reported mistreatment and abuse, including physical and verbal abuse, discrimination, lack of privacy, and detainment. Key stakeholders engaged during study validation workshops suggested the following to address these issues:

- Government should establish a youth-friendly special desk where cases of mistreatment and abuse in health facilities can be reported and addressed.
- Key stakeholders, including parents, community-based organizations, and government, should provide psychosocial support for distressed pregnant and parenting adolescents.
- Health care providers, including nurses and midwives, should be trained to provide respectful and non-judgmental services to pregnant and parenting adolescents. Having youthful health care providers who are relatable to adolescents would also be beneficial.

Childcare recommendations

Adolescent mothers face difficulties in caring for their babies. The following are recommended to address these challenges:

- Establish low-cost daycare centers that adolescent mothers can afford.
- Establish safe houses for adolescent mothers in Korogocho where parenting adolescents can drop off their babies in the morning and pick them up in the evening.
- Encourage parents of pregnant and parenting adolescents to support them with childcare.
- Incorporate cash transfers and daycare support as part of vocational training interventions.

Livelihood recommendations

Most pregnant and parenting adolescents were out of school, vocational training, or employment. This puts these girls at risk of cyclical poverty, with dire implications for their health and well-being and that of their children. The following are recommended to address these challenges:

- Governments and community-based organizations should provide vocational training opportunities for pregnant and parenting adolescents.
- Leaders such as members of the county assembly should introduce a bill to reduce vocational training fees in technical vocational education and training colleges.
- Government and parents should provide financial support for pregnant and parenting adolescents.
- Community-based organizations or non-governmental organizations should assist pregnant and parenting adolescents in setting up businesses.

Intimate partner violence

Close to half of the girls had experienced gender-based violence, and less than half of them (45.5%) sought help. Over half of the girls who sought help (52.7%, n=131) did so from their own family, while 18.3% sought help from their partner's family. To improve access to gender-based violence services, the following are recommended:

- Government and community-based organizations should provide emergency toll lines for people to call and report cases of intimate partner violence.
- Government and community-based organizations should set up referral pathways to ensure the girls get help.

School re-entry

About two out of five (42%) pregnant and parenting girls desired to return to school but were unable to due to several challenges, including lack of childcare support, financial difficulties, parental opposition to schooling, and a hostile school environment. The following are recommended to address these challenges:

- Government, through the Ministry of Education, should sensitize teachers and students to stop discrimination against parenting adolescents who return to schools and should respect pregnant and parenting adolescents' rights to an education free of stigma and discrimination.
- Relevant stakeholders should provide financial support for school fees, school uniforms and books, and child upkeep.
- Schools should allow breastfeeding breaks for parenting girls.
- Grandparents should look after the babies while adolescent parents return to school.
- Parenting girls should avoid negativity from peers, parents, and the community.
- Members of county assemblies or Parliament should provide bursaries for adolescent parents through the constituency bursary funds.

Introduction

The rate of adolescent childbearing in sub-Saharan Africa is among the highest globally, with 26% of girls starting childbearing before age 18, compared to 15% globally.[1] According to the 2022 Kenya Demographic and Health Survey, about 15% of girls in Kenya begins childbearing before their 19th birthday.[2] The national average masks within-country inequality in adolescent childbearing prevalence. Disaggregated data show that girls from poor households are by far the most affected,[3] with rates as high as two in five girls. The burden of adolescent childbearing is higher in urban slums than in non-slum urban areas.[4] The high burden of early—often unintended—childbearing is driven by factors such as poverty, sexual violence, lack of accurate knowledge about prevention measures, limited access to contraceptives, restrictive sexual and reproductive health (SRH) policies, and lack of policies and programs.[3] Although the government has expressed an aspiration to end early and unintended pregnancies, implementation of effective, evidence-based interventions is lacking.

Progress in reducing early and unintended pregnancy among girls remains slow, and many girls are impacted by consequences to their physical health and socioeconomic well-being. Studies have shown that adolescent girls are more likely to experience childbirth complications or die from pregnancy than older women.[5 6] Further, pregnancies disadvantage girls by limiting their chances of completing school or acquiring vocational skills.[7-9] This, in turn, harms their economic empowerment and worsens gender inequality. Children of adolescent mothers also feel the effects of early and unintended pregnancies. Studies have shown that children of adolescent mothers are more likely to perform poorly in school than children of adult mothers.[10 11] Early and unintended pregnancy, therefore, initiates a circle of social exclusion for girls. Their exclusion starts from their voluntary withdrawal or expulsion from school. Because of limited options and support, girls who experienced early unintended pregnancies often choose to enter marriage, risking intimate partner violence and forfeiting school.[12] Without intervention, the disadvantages of early and unintended pregnancy could be a significant impediment to realizing Sustainable Development Goal 5: Achieve gender equality and empower all women and girls.

The need to develop programs and policies that support the empowerment of pregnant and parenting adolescents is paramount, given that millions of girls start childbearing in their adolescence in Africa. Such interventions must be guided by rigorous and contextually relevant evidence. Interventions that are not informed by evidence risk neglecting areas with the most need and wasting scarce resources. Gender-transformative interventions are the most effective in improving the well-being of girls, but such interventions must come from the affected groups.[13]

Gender-transformative interventions are the most effective in improving the well-being of girls, but such interventions must come from the affected groups.

Building on previous surveys on the lived experiences of pregnant and parenting adolescents in Malawi[14] and Burkina Faso,[15] we conducted a mixed-methods study on the lived experiences of these girls. The study was implemented by the African Population and Health Research Center (APHRC), Miss Koch Kenya, and the Nairobi County government. In response to the reports on increased adolescent childbearing due to COVID-19, Miss Koch Kenya, a community-based organization working in Korogocho, in partnership with the Nairobi County government embarked on efforts to document the cases of pregnancies and childbearing among underage girls in Korogocho, an informal settlement or slum in Nairobi. Working with community health volunteers and community leaders, they identified 412 cases of pregnant and parenting adolescents in Korogocho, a staggering figure well beyond their projection of 80 cases. The youngest of the girls was 12 years old.

Problem statement

While a constellation of governments, advocacy actors, researchers, and partners has focused their attention on reducing teenage pregnancy, there is less focus on the well-being of the millions of pregnant and parenting adolescents in sub-Saharan Africa (SSA). We know little about their lived experiences, including how they perceive their roles as parents, the challenges they experience, and the support they need to improve their life chances. Further, evidence on the rate and correlates of school re-entry among adolescent mothers and how the availability of school re-entry policies, or lack thereof, hinders or facilitates their readmission is limited in SSA. The limited studies on this topic mainly adopt a qualitative approach. While useful, qualitative studies do not help us know which issues are most salient across different groups of pregnant and parenting adolescents. Therefore, we conducted a mixed-methods study of pregnant and parenting adolescents in Korogocho to document their lived experiences, examine their health and social well-being, and assess school re-entry gaps in both policies and practices.

Theoretical framework

We drew on Amartya Sen's social exclusion framework[16] to understand the lived experiences of pregnant and parenting adolescents as they cope with their new realities. Our central proposition is that the lack of inclusive policies and programs to support them fosters gender inequality in educational outcomes, with devastating consequences for girls, which manifest throughout the life course. The impact of exclusion extends to families and communities through reduced capabilities to provide care and contribute to the common good.

We argue that social exclusion is cyclic;[17] disadvantages further marginalize excluded groups. For example, government policies and programs fail to ensure equitable access to SRH information and services for adolescents in SSA countries. As a result, adolescents, especially those from poor households, are prone to adverse SRH outcomes, including early unintended pregnancy. With unintended pregnancy, they experience hindrances to benefiting from investments in education and health that will guarantee their empowerment, economic mobility, and improved health across the life course.[17 18] This exclusion continues as it further impacts children born to adolescent girls. Adolescent mothers' children are marginalized because of their parents' limited resources to care for them, resulting in their vulnerability to early unintended pregnancy, disempowerment, and lack of economic mobility.

Pregnant and parenting adolescents' return to school depends on the level of support and resources available for their education. Such resources and support are unequally distributed and are beyond the reach of most pregnant and parenting adolescents in SSA, who typically come from low-income families. Addressing their social exclusion will require progressive policies that address their peculiar needs. But beyond policies, it will require thoughtful design and implementation of accompanying interventions. Sociocultural factors like religious norms constrain the government from addressing the exclusion of adolescents from accessing SRH information and services. Nevertheless, such constraints do not exist in developing progressive policies to improve the educational outcomes of pregnant and parenting adolescents. Quality evidence can be useful in advocating for such progressive policies and guiding implementation. This framework leads us to trace the trajectory of social exclusion among pregnant and parenting adolescents, as highlighted in the research objectives.

Study objectives

The main aim of this study was to understand the lived experiences of pregnant and parenting adolescents as they navigate pregnancy and parenthood. The specific objectives are as follows:

- To document how the social exclusion and other related drivers (e.g., lack of inclusive policies, limited access to services and resources) compound pregnant and parenting adolescents' vulnerability to early unintended pregnancy
- To describe pregnant and parenting adolescents' experiences in health facilities
- To document the mental, social, and livelihood impacts of adolescent childbearing
- To describe how adolescent girls navigate early motherhood and parenting, including sources and nature of support received
- To assess the factors that hinder or facilitate school re-entry among pregnant and parenting adolescents
- To describe concerns, aspirations, and perceived life chances of pregnant and parenting adolescents
- To explore what low-cost, scalable interventions can enhance pregnant and parenting adolescents' access to education and livelihood opportunities, as well as improve their health outcomes

Study design

We conducted a concurrent equal status mixed-methods study in the Korogocho settlement of Nairobi to understand the lived experiences of pregnant and parenting adolescents, including how pregnancy has impacted their lives, physical and mental well-being, aspirations, and life chances.

Study sites/locations

Korogocho is one of the largest slums in Kenya and is home to approximately 200,000 people. It is characterized by poor infrastructure and overcrowding. It is one of the slums included in the Nairobi Urban Health and Demographic Surveillance System (NUHDSS) operated by APHRC since 2002. Previous studies have demonstrated that slum residents have the worst health and socioeconomic outcomes of any group in Kenya.[19-21] Residents face limited access to water and sanitation as well as to education and employment. In addition, they are exposed to violence and social unrest.[22]

Study participants

Study participants consisted of four groups:

Group 1: girls aged 10 to 19 years who were pregnant or had a biological child

Group 2: parenting boys aged 10 to 19 years who had accepted responsibility for the pregnancy and were actively supportive in raising the baby

Group 3: primary caregivers (parents or guardians) of pregnant and parenting adolescents (selected purposively based on their availability)

Group 4: teachers and policymakers, community and religious leaders, health care workers, and representatives from community-based organizations and non-governmental organizations

Only those participants who gave their consent or assent and could complete the interviews in English or Kiswahili were included in the study.

Sampling procedure

Quantitative survey

We estimated that a sample size of 500 pregnant and parenting adolescent girls was needed for the quantitative survey. We determined the minimum sample size using a formula for calculating the sample size of an observational study with an infinite population, 95% confidence interval, error margin of +-0.43, and prevalence of adolescent childbearing of 15%.[2] We conducted household listing in the study site to identify households with eligible adolescents. Overall, 2,500 structures and 8,000 households were listed. A total of 644 eligible girls was listed; 594 were interviewed successfully.

Qualitative interviews

We used purposive sampling to select the respondents for the qualitative study. We interviewed 10 adolescent fathers and 22 pregnant and parenting adolescent girls, 10 parents, 4 teachers, 7 community/religious leaders, 5 health providers, 3 policymakers, and 2 people working with civil society organizations. The 22 girls who took part in the in-depth interviews were excluded from the survey. Parenting adolescent boys were identified through a local non-governmental organization based in Korogocho that implements interventions targeting young people. We conducted 62 in-depth interviews and 21 key informant interviews. The interviews were sufficient to generate rich data on the perspectives of the community on issues affecting pregnant and parenting adolescents as well as possible ways of addressing them. The full breakdown of respondents in the qualitative arm of the study is presented in Table 1.

Table 1: Overview of sample selection for the qualitative study

RESPONDENT CATEGORY	
In-depth interviews	
Pregnant and parenting adolescent girls (10–19 years)	22
Parenting boys (10–19 years)	10
Parents/guardians	10
Key informant interviews	
Teachers/school principals/school directors/school district managers/parent–teacher association representatives	4
Policymakers at the county government	3
Religious/community leaders	7
Representatives from civil society organizations	2
Health workers	4
Total	62

Data collection and analyses

Quantitative survey

Twenty qualified and properly trained research assistants administered structured questionnaires to pregnant and parenting adolescents. Research assistants were trained in research ethics, study instruments, and skills for conducting interviews with adolescents and on sensitive topics.

The survey questionnaire was adapted from the Global Early Adolescent Study toolkit, John Cleland's illustrative questionnaire for interview surveys with young people, the Adolescent Girls Initiative–Kenya survey, the Transitions to Adulthood questionnaire, and the Protecting the Next Generation questionnaire. The questionnaire collected information on the background, family, and neighborhood characteristics of respondents; their sexual behavior, contraceptive knowledge, access, and use; parental communication;

mental health; unintended pregnancy; effects of unintended pregnancy on health and education well-being, and school re-entry. We conducted a pilot study among 30 adolescents in Kibera to ensure that respondents clearly understood the questions; we used their feedback to improve the questionnaire further.

Quantitative data were collected electronically using SurveyCTO, a survey platform for data collection based on the Open Data Kit, installed on Android tablets. All devices were password protected, and data collected were synchronized to a secured server at the end of every day. These devices were configured so that APHRC would receive the data in real time and monitor the progress of data collection. Data checks were inbuilt to ensure that only complete data were synchronized to the survey. Survey data were transferred to Stata for further cleaning and analyses. We used descriptive and inferential statistics to summarize the data.

Qualitative interviews

Each interview was conducted in a private space and tape recorded. Interviews were conducted by well-trained research assistants who were university students or graduates. Notes were taken to ensure context was provided for our transcripts; these notes documented verbal cues. Each interview was approximately one hour.

All recorded interviews were translated and transcribed into English by bilingual transcribers. To ensure transcription accuracy, we compared the transcripts of three interviews with the original recording. The transcribed data were imported into NVivo 12 for data coding. Inductive and deductive coding was done by four researchers, and discussions were held with the project lead to compare codes and ensure consensus. We used thematic analysis to ensure that all relevant information was coded and grouped into themes. Our themes were discussed with the entire research team to ensure they accurately captured respondents' narratives. A highly experienced qualitative researcher analyzed a random sample of our data and field notes to ensure the credibility of our analysis.

Ethical considerations

Ethical approval was sought from APHRC's internal ethics review committee and the AMREF Health Africa's Ethical and Scientific Review Committee. Research assistants were trained in research ethics before fieldwork commenced. We sought respondents' written informed consent after they had clearly understood the aim of the study and the voluntary nature of the study and had consented to the use of their data. We obtained parental consent and assent from minors (those younger than 18 who were residing with their parents). The study participants reserved their right to decline to answer any questions they were uncomfortable with or withdraw their participation from the study at any point. We ensured the utmost privacy during interviews by administering questionnaires in private spaces provided by a community-based organization offering services to adolescents at the study site. Each participant received a small token of 300 Kenyan shillings (approximately 2.5 United States dollars) at the time of the interview as compensation for their time and in line with APHRC's policy and ethics committee recommendation. We requested to see girls' IDs and hospital cards to verify their ages. All data were anonymized, and participants' privacy and confidentiality were respected at all times.

Findings

Sociodemographic characteristics of quantitative survey participants

Table 2 presents the sociodemographic characteristics of girls who took part in the quantitative survey. Their mean age was 18 years (SD 1.0) years. Most girls lived in cities (61.5%), were Protestant Christians (55.1%), had attended school (99.2%), had at least secondary education (55.5%), had worked for pay (61.9%), had never been married (47.8%), and had given birth once (72.1%).

Table 2: Sociodemographic characteristics of pregnant and parenting adolescent girls

Variable	Frequency (n=594)	Percentage
Age		
13–16	49	8.3
17	93	15.7
18	230	38.7
19	222	37.4
Residence		
City	365	61.5
Countryside	124	20.9
Town	98	16.5
Constantly moving/both	7	1.2
Religion		
Catholic	158	26.6
Protestant	327	55.1
Muslim	54	9.1
Traditional	13	2.2
No religion	42	7.1
Highest level of education		
No formal education	5	0.8
Primary	255	42.9
Secondary	327	55.1
College	7	1.2
Ever worked for pay		
Yes	367	61.9
No	227	38.2
Marital Status		
Never married	284	47.8
Married	101	17.0
Living with partner	65	10.9
Separated	123	20.7
Divorced	15	1.5
Widowed	6	1.0
Parity		
Pregnant	97	16.3
One child	428	72.1
Two or more children	69	11.6

The context of adolescent pregnancy

Muthoni's case

"I did not know that is how one gets pregnant."

Muthoni is a 16-year-old girl who lives with her aunt, sickly grandmother, and baby in a single-room shack at the heart of Korogocho. Her mother and father separated and got married to different people.

"My father does not support me; he never paid my school fees or bought me clothes." As the only income is from her aunt's menial jobs, they sometimes go without food. Muthoni was in class seven (14 years old) when she met Brian, an 18-year-old boda-boda (motorcycle) rider, who liked her and asked her to marry him. He would buy her chips and soda, which she happily accepted because of the livelihood difficulties she experienced at home. Despite her fears of getting married early, Muthoni accepted his advances. When they met, they did not talk about contraceptives or pregnancy. Muthoni then found out about her pregnancy and told Brian. Brian denied paternity outright and left Muthoni to her own devices. Muthoni had to drop out of school because of the discrimination from fellow students who constantly laughed at her.

Like Muthoni in the case study above, many girls engage in sexual relationships with older (68.4%) or similarly aged (30.3%) male partners and, because of limited knowledge about contraceptives, some become pregnant. The quantitative survey shows that 76.7% of pregnant and parenting girls had an unintended pregnancy. Most were single (71.9%) at the time of their first pregnancy, and 49.3% were still in school. A majority of the girls had sex for the first time with their boyfriends (86.2%), and only 37.5% willingly engaged in their first sexual experience. Over a third of them (35.9%) were unsure if they were willing to engage in sex, while slightly over a quarter of them (26.6%) were unwilling but were coerced into it. Most of them had their sexual debut while still in school (73.7%), and more than half did not use condoms the first time they had sex (56.2%). Girls reported that individual, family, peer, and structural factors predispose them to early and unintended pregnancy (see Figure 1). The individual factors include curiosity about sex, poor knowledge about contraceptives, and ignorance. As stated by one parenting girl:

> *"I did not think it would end up that way because we had unprotected sex and he told me that he withdrew before he could ejaculate." (IDI participant 14, parenting girl, 19-year-old)"*

At the family level, the breakdown of families, family conflict, limited support, and lack of parental supervision exposed girls to early and unintended pregnancy. Most girls interviewed were from broken families. They narrated how the conflict between their parents affected their childhood. The eventual breakdown of families means girls lacked a stable home environment to thrive.

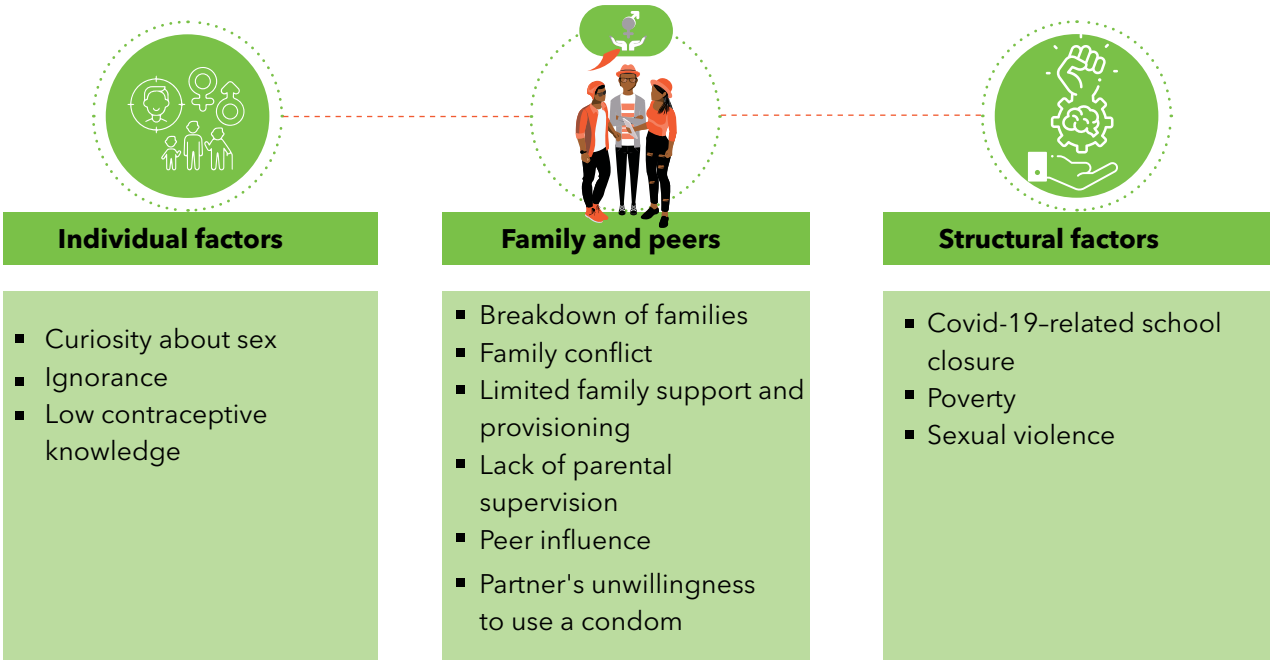


Figure 1: Socioecological factors associated with early pregnancies among adolescents

While many girls lived with their mothers, a few lived with their fathers or with a foster family. Living with a single mother in Korogocho was described as "tough," as most mothers engaged in menial jobs to cater to their families' needs. When parents went to work, girls would be inadequately supervised. In an attempt to help their parents or to meet their own personal needs, they would respond affirmatively to sexual advances from boys and men, who would promise them money and material gifts in return for sex. One of the interviewees, who got pregnant at 17 and now has a six-week-old baby, recounted:

> *Let's say that mum did not have a good job and so sometimes I don't even have money to buy books and so had to go to that guy to ask him for the money and he used to give me. If he didn't have money, he would give me 300 shillings. I used to buy books, and sometimes I would buy clothes. Sometimes she was like, why are you asking for money from that guy, but I told her I needed money for books. During that time, we were not living with my dad because they had separated. So, she rented her own house."*
>
> (IDI participant 15, parenting girl, 17-year-old)

Peer pressure pushed girls and boys to engage in sex and thus put girls at risk of early and unintended pregnancy. Adolescent boys were also noted to lack accurate information about contraceptives and parental supervision, abuse alcohol and drugs, and be curious about sex, leading them to get their girlfriends pregnant. Girls also blamed their pregnancies on their partner's unwillingness to use a condom.

> *We would normally have used a condom, but it was in a club and everyone was drunk and we didn't see it as a big deal. Later on is when she told me that she had become pregnant.*
> (IDI participant 9, parenting boy, 17-year-old)

Structural factors like poverty, sexual violence, and COVID-related school closure pushed girls to engage in transactional sex and increased their vulnerability to early and unintended pregnancy.

Maria's case

"It's like everyone turned me into a ball, kicking me around; nobody wanted me."

Reactions to adolescent pregnancy

Maria got pregnant at age 17 while still in school. Before her pregnancy, she was living with her father and stepmother. However, she now lives alone with her baby, since her boyfriend abandoned her three weeks ago after a misunderstanding. Maria found out she was pregnant four months into her pregnancy. In her words: "I was very worried; I immediately thought of taking poison or getting someone to help me abort the pregnancy." When her father found out she was pregnant, "he was very, very angry"; he chased her away from home because her stepmother did not want her there:

"my father was the one who sent me away from home at 10 p.m. … I went to stay with the father of my baby who lives a few houses away from my father's house that night."

The father of the baby was happy and accepted to have her stay with him. Shortly after, Maria's father came back and chased her away from the boy's place with threats. She then ran to stay with her maternal family, but they rejected her. Maria's classmates supported her and even bought her baby clothes, although some of them gossiped about her. Some older women from her local church encouraged her through the pregnancy, and some offered food and a place to stay. Finally, Maria met a woman who gave her a job as a house helper, where she got a place to stay and some money. "I was lucky I got that job."

Girls' reactions to early and unintended pregnancy

Like Maria, many girls were gripped with fear (50.3%) and disappointment (25.6%) after finding out they were pregnant. Girls' fear was related to how their parents, friends, and community would react to the news of them getting pregnant. They were disappointed because of their perception that pregnancy will hinder their future goals. Early and unintended pregnancy also meant they had placed an additional burden on their poor parents. Fear of parental reactions led some to run away from home and consider abortion, as one of the girls observed:

> After I tested and found out that I was pregnant, I was very stressed. I wanted to abort the pregnancy because my father is very harsh. I went to a pharmacy and asked how much it would cost me to have an abortion.
>
> (IDI participant 15, parenting girl, 17-year-old)

A few girls, however, expressed happiness (17%). Many of those who were happy about being pregnant were those who were married at the time of their first pregnancy (69.6%). More girls who were already out of school (28.2%) before getting pregnant were likely to state they were happy, compared to girls still in school (5.5%).

"I was being tossed around like a ball": Parents' reactions to their daughter's pregnancy

Most parents (63.5%) were very upset about their daughters becoming pregnant. However, 12% of them were happy and 15.7% were neutral. Parents were most likely to be very upset if their daughter was in school at the time she became pregnant (78.5%) than if she was out of school (48.8%). The qualitative findings corroborate the quantitative findings. According to the girls interviewed, their parents were very upset and disappointed in them. Parents had high hopes for their girls and invested heavily in their education to secure their future. Many parents were disappointed because they considered early pregnancy as a stumbling block that could harm their daughter's future and socioeconomic well-being.

> My father and I became enemies. He hated me. He could click whenever he saw me; he wanted nothing to do with me. Sometimes he could talk to me rudely to the extent of even insulting me. I used to cry and even started to think about running away from home.
>
> (IDI participant 15, parenting girl, 17-year-old)

Parents expressed their disappointment by beating their pregnant girls and kicking them out of their homes and, in a few instances, demanding the termination of the pregnancy. One girl stated:

Interviewees reported that their parents refused to pay their school fees or provide for their other needs. However, a few girls narrated how their parents later accepted the situation and supported them with financial and material resources and even acted as babysitters when they chose to go back to school.

"He said the pregnancy was not his": Partners' reactions to girls' early pregnancy

While about 46% of girls noted that their partners were happy about their pregnancy and supported them, paternity denial was rife, affecting approximately 31% of girls. The qualitative interviews elucidated the reasons for paternity denial. Girls recounted that boys denied paternity after failed abortion attempts and because they were not financially ready for or capable of starting a family.

> He said the pregnancy was not his and that I should look for the person who made me pregnant so that he could take responsibility.
>
> (IDI participant 7, parenting girl, 18-year-old)

One girl recounted her partner's reaction:

"They used to laugh at me": Community reactions to adolescent pregnancy

Girls interviewed in the study stated that community reactions to their pregnancy were mostly negative. Members of the community blamed their parents for negligence, not raising them well, and using them to obtain money from men (more or less like selling them for financial gain). Some community members even stopped their daughters from associating with pregnant and parenting girls and would physically abuse them for failing to comply. Pregnant and parenting girls were ridiculed, discriminated against, gossiped about, and excluded in the community. One of the girls commented:

> … they would backbite me when I pass; they would talk about me and backbite me. Some would laugh, others would talk and laugh loudly and even clap their hands. Then you wonder what kind of things are these people doing. So, I just decided to stay at home.
>
> (IDI participant 1, parenting girl, 15-year-old)

A few girls, however, mentioned that some community members accepted, encouraged, supported, and motivated them. The support offered by some community members included providing them with baby gifts and regular counseling and encouragement. In a few instances, when the girl was very young, elderly women in the community threatened to arrest the man responsible for the pregnancy, but parents often objected to involving law enforcement.

Experiences with prenatal and delivery care services

Use and timing of antenatal care attendance

A vast majority of girls (92%) accessed antenatal care services. About 42.4% saw doctors, and one third of them (32.8%) saw nurses. However, in the qualitative interviews, many girls reported that they did not seek antenatal care in the first trimester, as recommended by the Ministry of Health. Instead, they sought antenatal care late, either in their second or third trimester, as captured below:

> I went to the clinic three times… Seven, eight and nine [months].
>
> (IDI participant 10, parenting girl, 17-year-old)

Health workers also alluded to adolescent girls presenting late for antenatal care:

> If parents or guardians do not take the initiative, it is difficult for the teenager to present themselves to the hospital. Hence, most of the time you find that maybe they just come for delivery [laughs], or they come in their third trimester, having completely concealed the pregnancy to the extent that you may not even notice that they are pregnant. So, they mostly come for the visit in their third trimester.
>
> (KII participant 2, female health provider, 31-year-old)

Only 34.6% of girls surveyed completed four antenatal care visits, and approximately 3% completed eight visits. While the majority of girls sought antenatal care services in clinics or hospitals, a few visited traditional birth attendants for services such as belly massages, which are believed to help in aligning the fetus in the right position, as explained below:

> The baby was on one side of the belly, so I went to another old man who helped me by massaging my stomach and switching the baby to the right position…
>
> (IDI participant 18, parenting girl, 17-year-old)

"I used to feel like the doctors will judge me": Barriers to early antenatal care initiation

Most pregnant adolescents presented themselves to the facility during the second trimester—with most presenting at four or five months—and some at the point of delivery. Some of the reasons for the late presentation at the facility were lack of support from parents and guardians, lack of knowledge of antenatal care, social stigma, isolation from community members, lack of money, providers' negative attitudes, shame, ignorance, and fear (see Figure 2).

Figure 2: Barriers to antenatal care attendance

"I saw it was too early to begin going to the clinic when I have 2 or 3 months, so it's better if I could begin at 4 months."

(IDI participant 4, parenting girl, 19-year-old)

"Just that shame: I feared going early because people would start talking. So, for me, I used to go while hiding myself."

(IDI participant 2, parenting girl, 16-year-old)

"At first I went to the city council one, but it was difficult because they were asking for 650 [shillings]. There were things I needed to get tested. And so, since mum doesn't have that money and even me I don't have, there is Fikira Jamii: my sister used to take me there and I started clinic and it proceeded. It is okay."

(IDI participant 5, parenting girl, 19-year-old)

"When you visit a public hospital, you don't pay anything but the doctors can be rude to you, reprimand, and even insult you. Whereas in private, it's your money that speaks: the doctor cannot just speak to you anyhow."
(IDI participant 15, parenting girl, 17-year-old)

"I had feared because I saw the doctors as if they will abuse me: I'm a child who is pregnant. I was fearing a lot (a bee buzzing) but I had to get used to it."

(IDI participant 4, parenting girl, 19-year-old)

"I used to feel like the doctors will judge me and look at me or even insult me. So I was generally afraid."

(IDI participant 16, parenting girl, 17-year-old)

"I did not pay a cent": Facilitators of antenatal care services during pregnancy

Key facilitators of prenatal and delivery care use among girls were free health insurance targeting women and girls in Kenyan slums and rural areas, such as the government-operated Linda Mama program, provider friendliness, community health volunteers, parents/guardians, friends, and partners. Maternity care programs such as Linda Mama and Mom Care made access to antenatal care and delivery possible for most girls. One parent alluded to this:

> "… I took a Linda Mama card for her and it helped a lot. For the medicine, I asked one social worker I know to help me, since she was required to take some pills. Linda Mama helped a lot. Luckily, the hospital was free. With the Linda Mama card, everything was catered for. I did not pay a cent."
>
> (IDI with parent 7)

Experiences in health facilities

More than one quarter of adolescent mothers reported verbal or physical abuse in health facilities (26.1%). Thirty-seven girls reported that they experienced physical abuse (6.2%) and 142 reported verbal abuse (23.9%) in the hospital. The most common type of physical abuse was fundal pressure (pressure on the uterus) (4%), followed by being slapped by health workers or hospital staff (1.7%). Most of the 37 PPAs who experienced physical abuse reported doctors as the perpetrators (62.2%). Further, nearly one third (29.7%) reported a midwife as the perpetrator, and 13.5% reported a trainee as the perpetrator. The most common type of verbal abuse was being shouted or screamed at by a health worker or other staff (16.5%), followed by being scolded by a health worker or other staff (9.8%). All 142 PPAs who experienced verbal abuse reported doctors as a perpetrator.

Table 3: Experience of physical and verbal abuse at the health facility

Variables	N=594 n (%)
Any hospital physical or verbal abuse	**155 (26.1%)**
Any hospital physical or verbal abuse	**37 (6.2%)**
Punched	6 (1.0%)
Kicked	0 (0.0%)
Slapped	10 (1.7%)
Hit	1 (0.2%)
Gagged	5 (0.8%)
Physically tied to the bed	2 (0.3%)

Held down on the bed forcefully	4(0.7%)
Fundal pressure	24 (4.0%)
Hospital verbal abuse by a health worker or other staff	**142 (23.9%)**
Shouted or screamed	98(16.5%)
Insulted	52 (8.8%)
Scolded	58 (9.8%)
Mocked	42 (7.1%)
Negative comments about physical appearance	24 (4.0%)
Negative comments about your baby's physical appearance	6 (1.0%)
Negative comments about your sexual activity	29 (4.9%)
Threatened with a medical procedure (e.g., caesarean section)	36 (6.1%)
Threatened with physical violence	5 (0.8%)
Threatened with a poor outcome for you or your baby	51 (8.6%)
Threatened to withhold care for you or your baby	11 (1.9%)
Blamed you for something that happened to you or your baby	10 (1.7%)
Hissed at you	13 (2.2%)
Other use of verbal abuse	10 (1.7%)

Eighty-five girls reported stigma or discrimination during their hospital visit (14.3%). Sixty-nine girls reported hearing negative comments about their age (11.6%), and 27 girls reported hearing negative comments about their marital status (4.5%). All girls who experienced stigma or discrimination reported that the negative comments were from a doctor.

Table 4: Reports of stigma and discrimination at the hospital during pregnancy

Variables	N=594
Any report of stigma or discrimination	85 (14.3%)
Negative comments about your ethnicity, race, tribe, or culture	8 (1.3%)
Negative comments about your religion	5 (0.8%)
Negative comments about your age	69 (11.6%)
Negative comments about your marital status	27 (4.5%)
Negative comments about your education or literacy level	18 (3%)
Negative comments about your economic circumstances	9 (1.5%)
Negative comments about your HIV status	4 (0.7%)

Of the 497 girls who had given birth, 491 gave birth in the hospital (98.8%). Analysis in this section is, therefore, limited to adolescent girls (n=491) who had given birth in health facilities. One in 10 adolescent mothers reported not having a hospital worker present during delivery. About 118 adolescent mothers reported having no privacy during childbirth, and 144 reported sharing a hospital bed with another woman. About 17% of adolescent mothers (n=81) reported detainment due to unpaid hospital bills. Most girls would recommend the hospital to a sister or friend (75.4%), but only 56.8% of those who intend to have more children (n=426) will use the same facility for future births.

Table 5: Experience of lack of privacy, neglect, and detainment

Experience of lack of privacy, neglect, and detainment	Frequency	Percent
Neglect and abandonment		
Staff member not present during childbirth admission	25	5.1
Staff member not present when the baby came out	50	10.2
Health system		
Curtains, partitions, or other privacy measures not used	118	24.0
Did not have a bed to herself during labor	62	12.6
Did not have a bed to herself during childbirth	34	6.9
Shared bed with another woman or women	144	29.3
Detainment (baby or woman detained in the hospital due to inability to pay hospital bills)	81	16.5
Birth outcome (baby not born alive)	7	1.43
Future birth intention (would like to have another child)	426	86.8
Place to have future childbirth based on recent experience		
Same hospital (n=426)	242	56.8
Different hospital (n=426)	172	40.4

However, most girls who participated in the qualitative interviews described the health care providers as friendly. They recounted how health care providers empathized with them and counseled them:

> "I mean, when I went there, they did not treat me in a bad way. When I got there, they just asked me if I was a student and I said yes, I was. Then she asked me why I agreed to get pregnant early. Then I told her the whole story and she told me not to give up, that's how life is and you can have your baby and go back to school..."
>
> (IDI participant 12, parenting girl, 18-year-old)

However, other girls labeled their interactions with health care providers as uncomfortable and stated that they were treated badly, as shown in Figure 3.

Fear of health care providers

"I used not to feel very comfortable, because whenever line queue was moving and I am next in line, I would feel like running away and go back because inside the room it's not just one doctor, it's like two or three doctors."

(IDI participant 16, parenting girl, 17-year-old)

Attitudes of health care providers

"Those doctors. They would say, 'You have gotten pregnant…' You just know, there are some doctors who talk to people badly…"

(IDI participant 14, parenting girl, 19-year-old)

Figure 3: Attitudes of health care providers

Mistreatment of girls was not limited to health providers, as adult patients were judgmental and discriminatory as well. Some girls overheard other patients gossip about their young age and speculate about their mode of delivery, as shown in the excerpts in Figure 4.

Gossip about age & mode of delivery

"They were saying, This girl is still young, she will deliver through caesarean."

(IDI participant 7, parenting girl, 18-year-old)

Rejection & exclusion

"Yes! They spit, saying that you smell bad. You talk badly about someone yet you yourself, you don't know how you are…"

(IDI participant 1, parenting girl, 15-year-old)

Figure 4: Treatment received from older mothers at the health facility

Satisfaction with care

As shown in Figure 5, the majority of girls felt that they had the opportunity to discuss any concerns (69.7%) and discuss any preferences or requests (66.2%) with their health care worker. Almost seven out of every 10 girls (71.5%, n=351) felt they made shared decisions about their care with their health care worker. The majority of adolescent mothers felt their privacy (79.0%) and cultural and religious needs (85.3%) were respected. Most girls felt there was adequate water (90.6%), cleanliness (88.4%), and electricity (97.4%) at the hospital. Approximately eight out of 10 girls (79.4%) were satisfied with the services they received during their hospital visit.

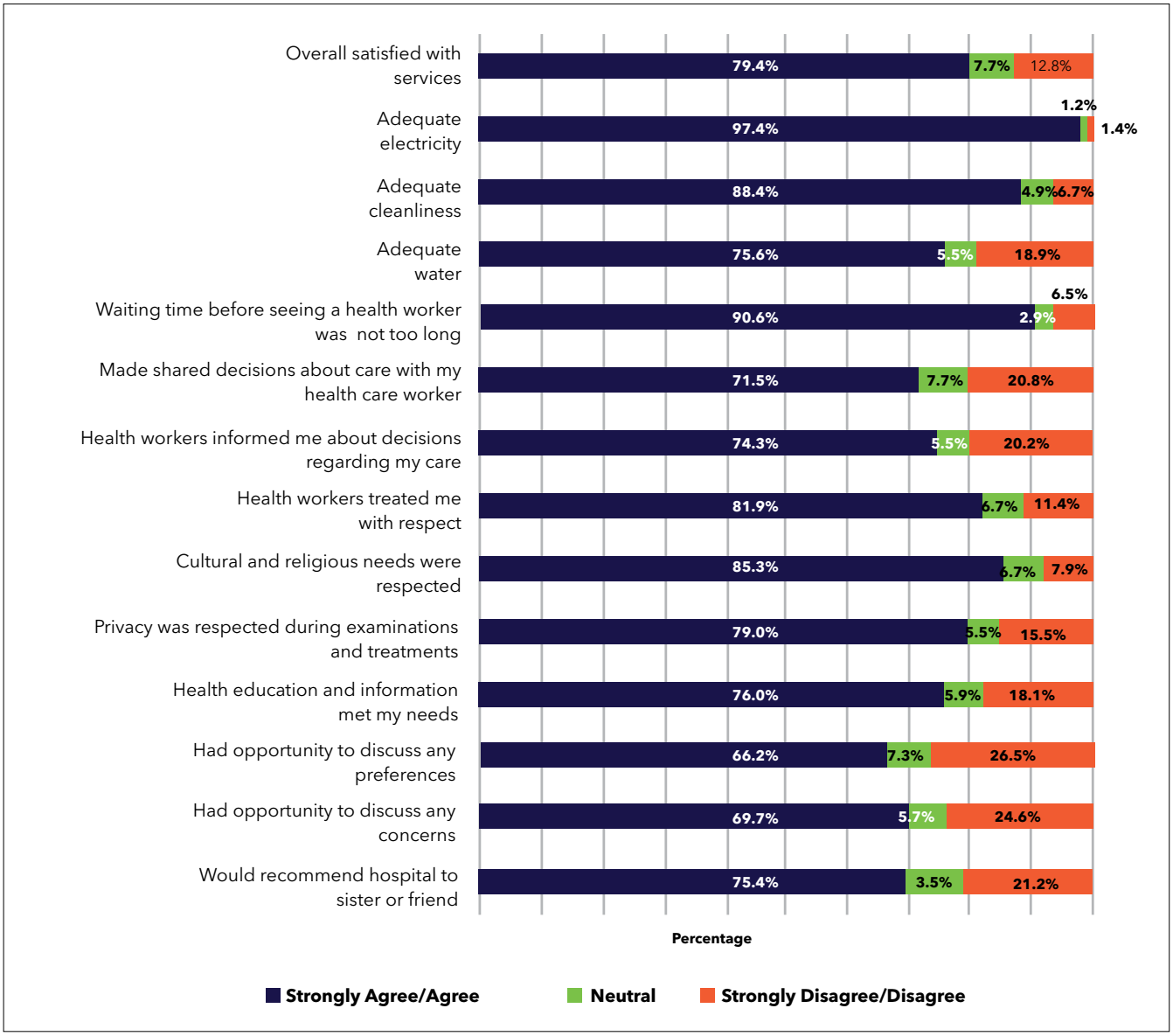


Figure 5: Level of satisfaction with aspects of care received

Obtaining birth certificates for children

Most parenting girls (86%) reported that they had not obtained their children's birth certificates. Key barriers to obtaining a birth certificate included their lack of ID cards (20.5%) and lack of money (20.1%) (Table 5).

Table 6: Barriers to obtaining a child's birth certificate

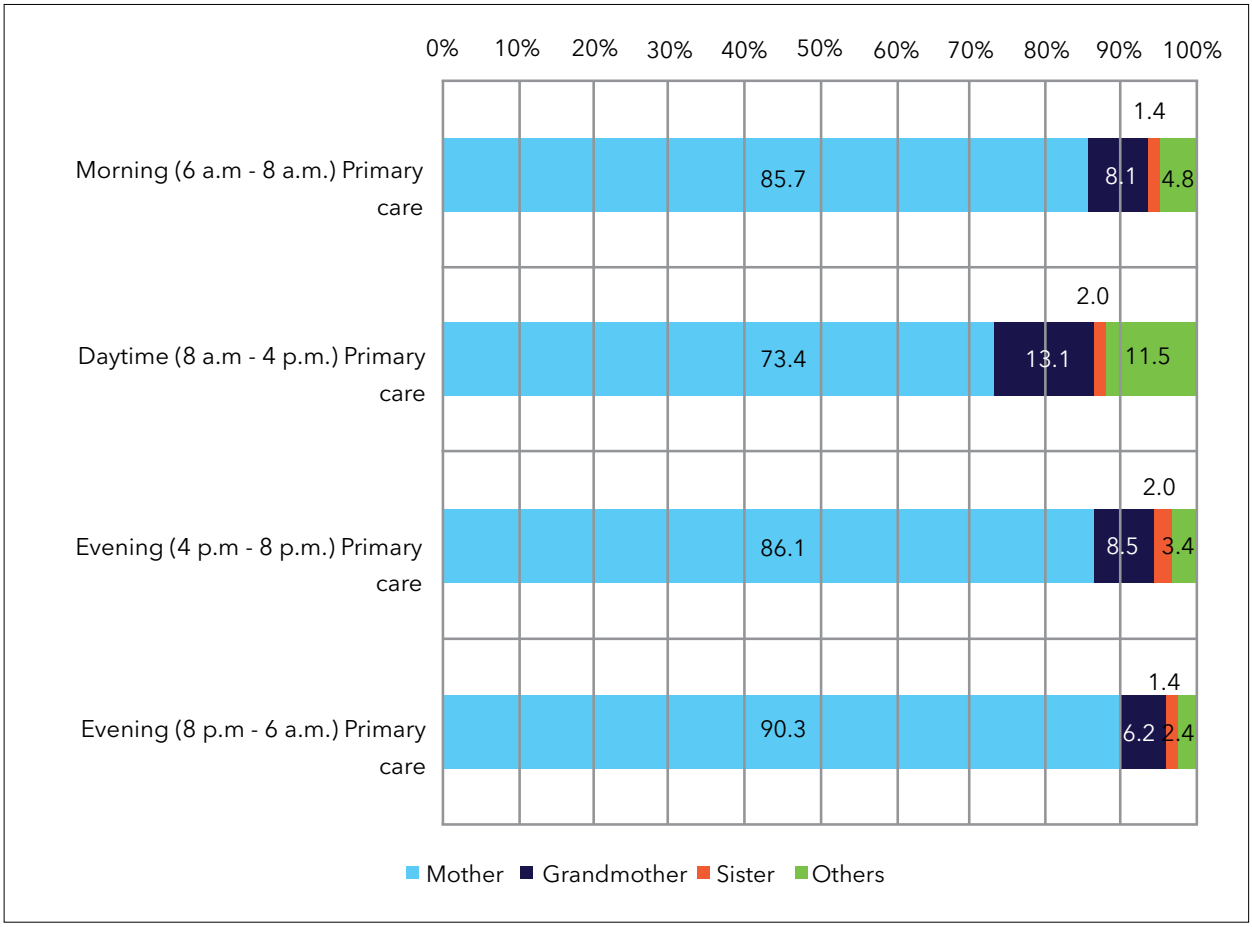
Barriers to obtaining a child's birth certificate	Frequency	Percent
Parenting girl lacks ID card	50	20.5
Lack of partner's ID card	12	4.9
Lack of money	49	20.1
Child death	4	1.6
Lack of birth notification	19	1.8
Birth certificate is being processed	6	2.5
Complex application process	12	4.9

Corruption	4	1.6
Lack of time	14	5.7
Lack of knowledge	14	5.7
Has not applied	30	12.2
Other reasons	30	12.3

Childcare support

About 74% of girls were somewhat to very worried about not being able to take care of their child, and 46% of adolescent mothers reported that they had no one to rely on. We asked parenting girls with children between the ages of 1 and 5 years about who in their lives provided primary and secondary care to their child(ren). The results show that the primary caregivers were largely the female members of the girl's family. Primary care was provided mostly in the morning (85%) and late-night hours (90%) by the parenting girl's mother. Grandmothers provided care in the daytime (13%) and evening (8.5%), as shown in Figure 6. A smaller percentage of the parenting girls reported other people providing primary care between 6 a.m. and 8 a.m. (brother [0.2%], biological father [0.2%], grandfather [1.0%], stepfather [0.2%], formal or informal daycare [1.2%]) and between 8 a.m. and 4 p.m. (neighbor/friend [2.6%], biological father [0.6%], brother/other relatives [1.8%], formal or informal daycare [4.7%]).

Figure 6: Caregiving support to parenting adolescents



Childcare challenges

Despite their mothers' support, adolescent girls bore the burden of childcare. The girls interviewed recounted how they combined childcare with house chores: "When I want to wash clothes, I wash one and she starts crying and then you have to stay with her until she sleeps so that you can wash the clothes until you finish" (IDI participant 22, parenting girl, 18-year-old). While they embrace this challenge, interviewees explained that nurturing their babies is fraught with several challenges. The critical challenge most parenting girls faced was a lack of money and jobs. Because of the burden of childcare responsibilities, they are unable to work or return to school. Being unemployed meant they were unable to adequately provide for their baby's needs, including medicines, food, diapers, and clothes. One of the interviewees recounted:

> "Sometimes the baby becomes sick and you do not have money, all you have is just capital for the business, which if spent on taking her to the hospital will leave you with no money for stock. So many challenges. Sometimes you do not have food or to pay rent, you just sit there wondering where the money is going to come from. I become stressed and think of what would have been if I had not gotten pregnant."
>
> (IDI participant 2, parenting girl, 16-year-old)

Childcare responsibilities also restricted their movements, as they are unable to socialize with friends like before. One interviewee recounted: "I can't move around easily; even now that I am here, I am a bit worried" (IDI participant 7, parenting girl, 18-year-old). Girls lamented that they received little or no support from the father of their baby. While some received no support from their children's father, others stated that their children's father provided support when he had a job. Those who depended solely on their mothers claimed that support from their mother was inadequate, as many mothers had a temporary job. On days that their partner and mother were unable to find jobs, they would lack basic baby needs like food and diapers, a challenge they often navigated by borrowing from friends and neighbors. If they were unable to borrow, they simply went hungry: "it's just lack of a job because sometimes when my mother doesn't have money, we just stay hungry because there is nothing I can do" (IDI participant 15, parenting girl, 17-year-old).

Daycare was described as unaffordable. As recounted by one interviewee: "I cannot be able to afford the amount daily because sometimes I make 200 shillings and it's your turn to buy food in the house and you cannot pay for the daycare and then sleep hungry" (IDI participant 7, parenting girl, 18-year-old). A few girls also feared leaving their children in daycare. The illustrative quote below alluded to this:

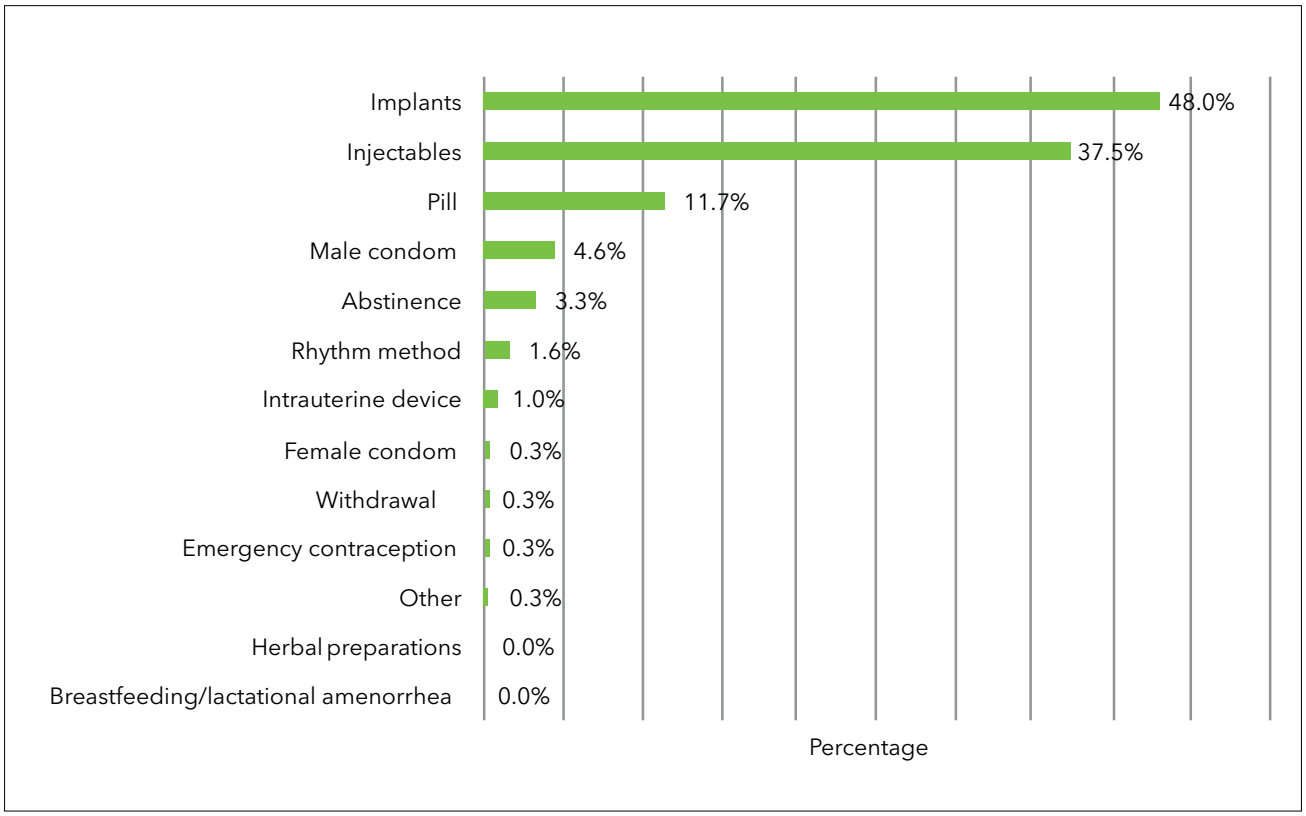
> "There was a time I used to go to work and she agreed to take care of the child but after one week she said I should take the child to daycare. I fear leaving my child at the daycare. I decided to quit and look after my child. I just wanted the baby to be fine even though sometimes there is no food."
>
> (IDI participant 7, parenting girl, 18-year-old)

Postpartum contraceptive uptake among parenting adolescents

Most parenting adolescent girls (63.4%, n=307) were using a form of birth control to delay or prevent pregnancy at the time of being interviewed. Among PPAs who reported "currently" using a birth control method, most were using implants (43.0%), injectables (37.5%), or birth control pills (11.7%) (see Figure

7). Fewer than 5% were using male condoms (4.6%), abstinence (3.3%), the rhythm method (1.6%), intrauterine devices (IUDs) (1.0%), female condoms (0.3%), withdrawal (0.3%), emergency contraception (0.3%), or other methods (0.3%). No girls reported using herbal preparations (0.0%) or relying on breastfeeding/lactational amenorrhea (0.0%).

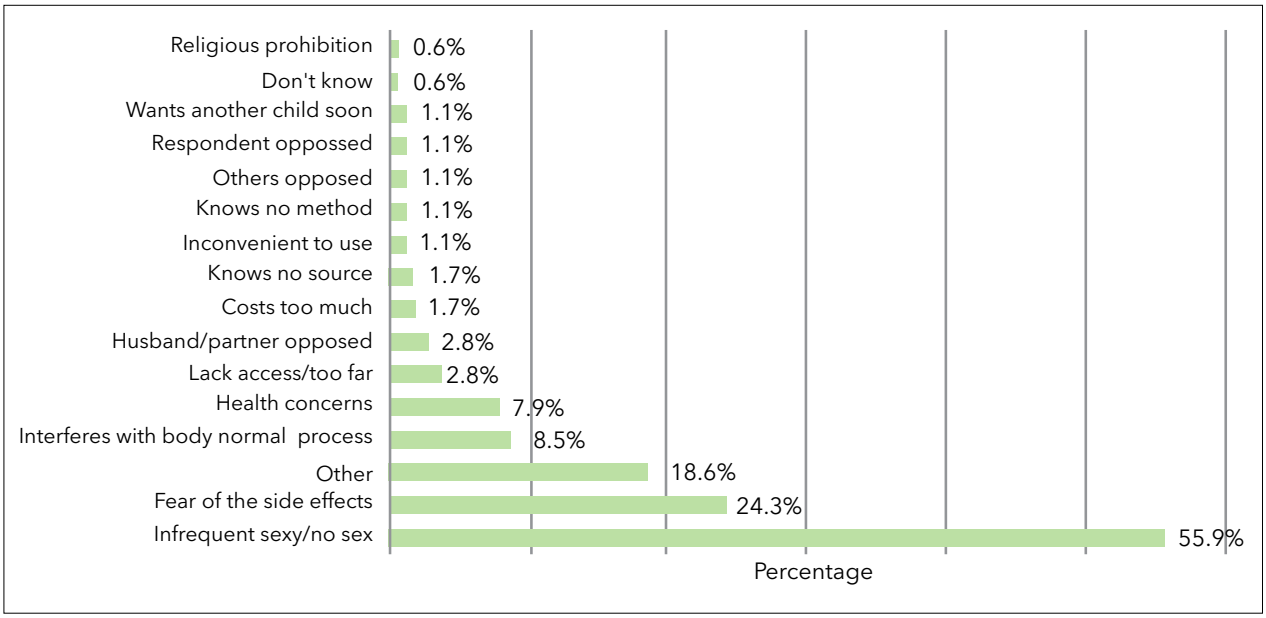
Figure 7: Birth control methods currently being used (n=307)



Reasons why girls were not using a birth control method

The most reported reasons for not using a birth control method included infrequent/no sex (55.9%) and fear of birth control side effects (24.3%) (see Figure 8). The remaining 20% of girls provided various reasons for not using birth control methods, including health concerns (7.9%), lack of access/too far (2.8%), and husband/partner opposed (2.8%).

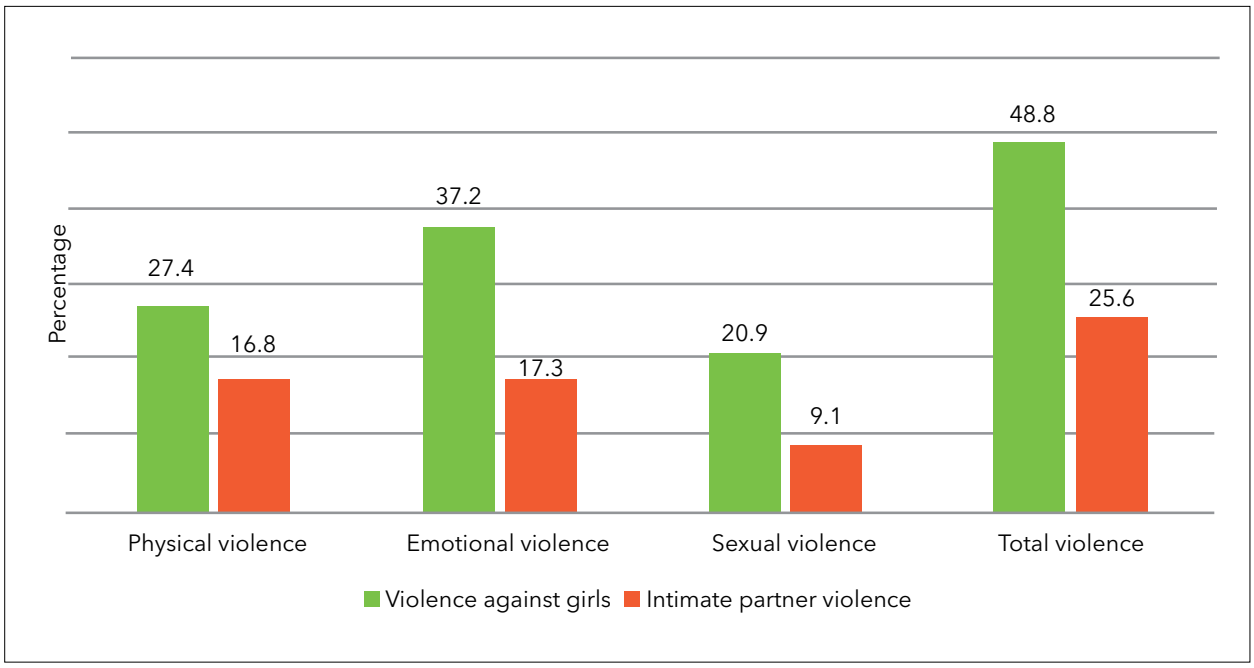
Figure 8: Reasons why girls are not using a birth control method (n=177)



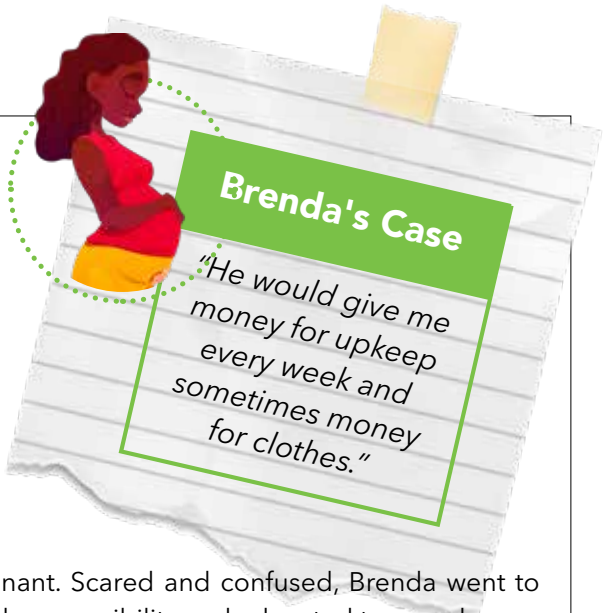
Violence against pregnant and parenting girls

As shown in Figure 9, close to half of the girls (48.8%) had experienced violence–physical, emotional, and sexual–from intimate and non-intimate partners. Girls were more likely to have experienced emotional violence (37.2%), followed by physical (27.4%) and sexual (20.8%) violence. Overall, 25.6% of girls had experienced intimate partner violence. Male friends, relatives, neighbors, co-workers, and strangers were also identified as perpetrators of violence against adolescent girls. Of the 290 girls who experienced violence, only 45.5% sought help. Over half of girls who sought help (52.7%, n=131) did so from their own family, while 18.3% sought help from their partner's family. About one fifth sought help from friends. Only 12.9% sought help from the police.

Figure 9: Exposure to violence against girls and intimate partner violence



Adolescent pregnancy and mental distress



Brenda is a 16-year-old girl who lives in a two-room shanty with her mother, father, and two siblings. Her parents mostly work in menial jobs such as garbage collection and laundry, which generate low wages that are unable to sustain the family's needs. Brenda was in grade 8 when she met her 19-year-old boyfriend, Mike, who had dropped out of school and survived by doing petty crime.

Three months into the relationship, Brenda became pregnant. Scared and confused, Brenda went to Mike's place to inform him of the pregnancy, but he denied responsibility and relocated to an unknown location. She attempted to abort the pregnancy several times by drinking concentrated tea leaves, but all her efforts were futile. She then resorted to concealing the pregnancy, but her mother found out at five months and informed her father. "They said I have brought shame upon the family and should take

my pregnancy to whoever made me pregnant." In the community, she could not walk around freely anymore due to being treated with contempt and parents warning their daughters to dissociate from her because she is a bad influence. Rejection and exclusion by her parents, teachers, and schoolmates led her to drop out of school. She became hopeless and began having thoughts of killing herself. "I was so sad to the extent of losing interest in living. I kept questioning, asking what have I done to myself?" She felt worthless and fell into depression until a local NGO decided to help her through the pregnancy and provided her with psychosocial support.

In Korogocho, most pregnant and parenting adolescents faced hardships that were similar to Brenda's. Most of them were mentally distressed because of unintended pregnancies and the challenges that ensued. They reported sadness, loss of appetite, guilt, self-isolation, shame, fear, worry, stress, suicidal thoughts, and self-harm, among other mental distress symptoms. One interviewee stated: "I immediately thought of taking poison or going to someone to help me abort the pregnancy" (IDI participant 12, parenting girl, 18-year-old). Another girl reported how being gossiped about, mocked, and constantly humiliated in the community made her have suicidal thoughts:

> "I was just feeling bad: what is this that I am into? I do not know what I would do. I just started thinking of bad things, the way I will kill myself, the way I will do this and that"
>
> (IDI participant 1, parenting girl, 15-year-old).

Findings from the quantitative survey show that 40% of PPA girls reported mild depressive symptoms and 35% reported minimal symptoms (see Figure 10). A quarter of the sampled population reported moderate to severe depressive symptoms (25.3%). However, a few girls reported having access to counselors.

> "During my counseling session they would teach me about contraceptives and encourage me, telling me that was not the end of life, I shouldn't be desperate and such things… my friend linked me up with a certain person and I started going for counseling sessions that made me okay until I gave birth"
>
> (IDI participant 19, parenting girl, 19-year-old).

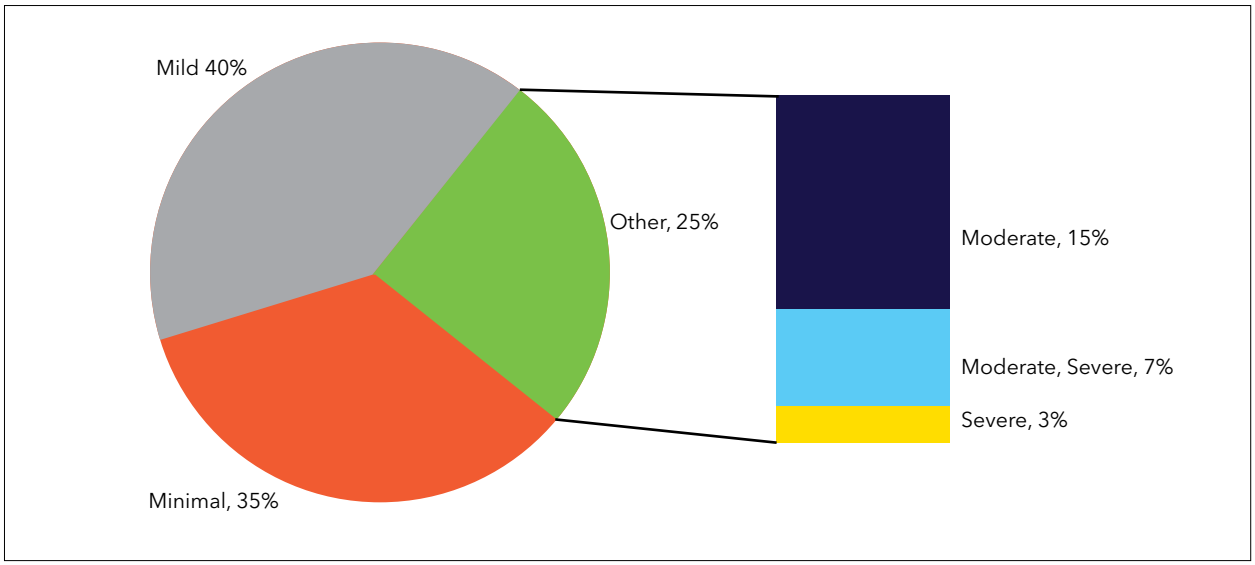


Figure 10: Prevalence of depression symptoms among pregnant and parenting girls

Barriers and facilitators of school re-entry among pregnant and parenting adolescents

Audrey's case

Audrey is a 17-year-old girl living with her mother, two siblings, and a 9-month-old baby in a one-room shelter in the margins of Korogocho. Her mother was dependent on alcohol and survived on sex work. The meager income she earned could hardly sustain her family, denying her daughter, Audrey, school necessities (books and stationery). While in form three (grade 11), Audrey met Gavin, a 25-year-old mechanic who became her boyfriend. She was reluctant at first, but the need to buy necessities–like food, menstrual pads, etc.–tempted her to agree to the relationship. He would take her out on dates and buy her gifts and school supplies. Audrey soon become pregnant but continued attending school regardless.

The pregnancy became visible and students would gossip about her, saying, "This girl is pregnant… if we sit with her, we will get pregnant." Upon learning about her pregnancy, Audrey's mother withdrew her financial support (school fees), forcing her to drop out of school. She desires to return to school to complete her secondary education, but she has no one to help her with childcare. She also lacks the money to support her schooling and care for her baby's needs, including baby formula and diapers. Her mother is no longer interested in supporting her education since she got pregnant: "I was willing to go back to school even though I had a baby… I accepted and even asked for forgiveness from my mother, but she refused." At the moment, Audrey has learned hairdressing, which she does to support herself, her baby, and her two siblings in school.

Only five of the 594 girls who participated in the quantitative survey had never attended school. About half of the rest dropped out of school due to unintended pregnancy. Approximately 91% of 589 girls who had attended school were out of school. Like Audrey, 42.4% of out-of-school parenting girls (n=535) wanted to return to school but were unable to do so due to several challenges, including lack of childcare support, financial challenges, parental opposition to schooling, and a hostile school environment (see Figure 11). Our study shows that the majority (79.3%) of girls who indicated an interest in returning to school would not want to return to the same school that they previously attended, mainly because of shame and stigma.

Worries about welfare and wellness of the child

"You start thinking of how your baby is. You've taken them to daycare; you don't know if the baby has eaten or not eaten. At the same time, the milk is coming out. Also, if you ask for permission to go breastfeed [it] is also an issue."

(IDI participant 2, parenting girl, 16-year-old)

Financial challenges

"I mean, this child comes with a lot of expenses like diapers; they also have to eat in the morning, by 1 p.m. and maybe 5 or 6 p.m. as well as at night. So, you do your math. Your child is used to eating like that and now you cannot provide because you are in school and so you become stressed thinking about what they ate, or what they wore. At times you do not even have soap to wash their clothes; I mean, it's a lot of things."

(IDI participant 13, parenting girl, 19-year-old)

Figure 11: Barriers to school re-entry

Parent's inability to pay for girl's school expenses

"If I say that I want to go back to school, my mother cannot afford to pay for my schooling."
(IDI participant 10, parenting girl, 17-year-old)

"My mother told me that she will help me raise my child just in the meantime and that I should look for something that I can do to help her, and so that is why I am saying that I cannot go back to school. I need to help my child."

(IDI participant 13, parenting girl, 19-year-old)

School environment is hostile to adolescent mothers

"Teachers would start talking about me or make jokes about me and I don't really want that."

(IDI participant 15, parenting girl, 17-year-old)

Facilitators of school re-entry

Figure 12 outlines the types of support that girls who intended to return to school (n=227) noted they would need to return to school. Almost all of them reported that they would need financial support (96.9%). More than half of them indicated that they would need childcare support (51.1%). Also, they would need school uniforms/supplies (39.2%), guidance and counseling (10.1%), and other support (6.6%). Other reasons provided included resources for themselves and their child (e.g., food, clothing, shelter) and a conducive learning environment.

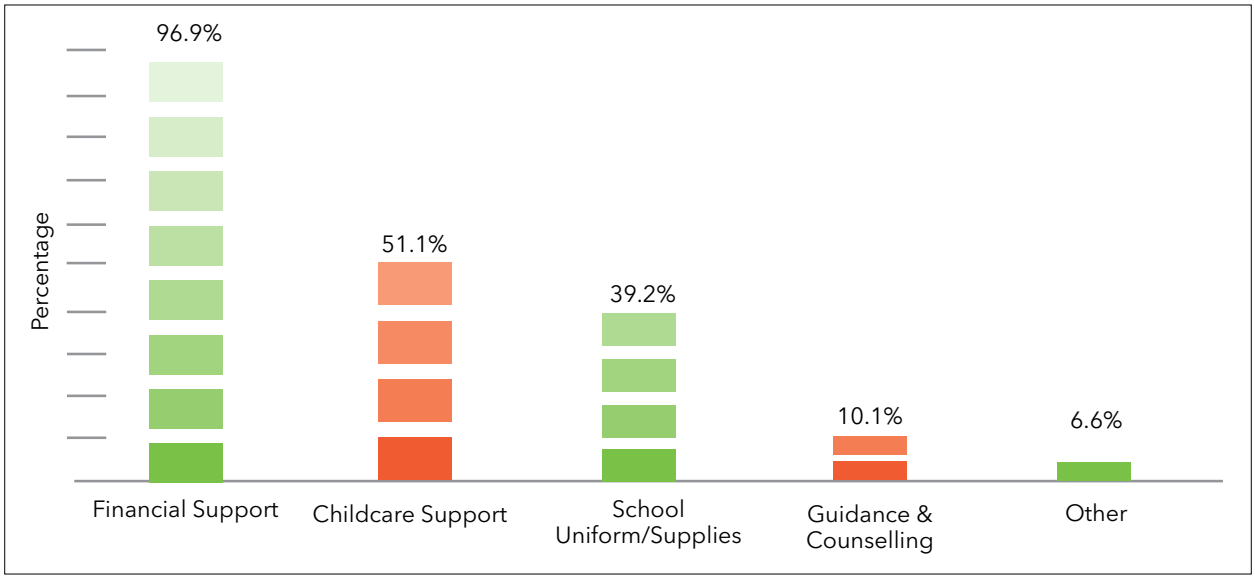


Figure 12: Form of support needed for girls to return to school

Qualitative interview data revealed several factors that would facilitate school re-entry. The main facilitators included the desire for a better future, special schools for teen mothers, acceptance in school, breastfeeding breaks, lack of discrimination, financial support, childcare support, advice, and encouragement (see Figure 13).

The desire for a better future

"The thing that can encourage me is my future because I had a future before all this but … I can go back to school."

(IDI participant 13, parenting girl, 19-year-old)

Special school for adolescent mothers

"They should at least have a special school instead of going back to the schools they were in or a school near their community where people know them. They go to the special school because everyone is equal since they have all had children or even been pregnant."

(IDI participant 14, parenting girl, 19-year-old)

Acceptance in school

"The teachers should be talked to for them to allow the girls back in school."

(IDI participant 15, parenting girl, 17-year-old)

"Allow them back in school and not treat them as parents because they can categorize the rest as students and the others as parents. They should treat them the same."

(IDI participant 14, parenting girl, 19-year-old)

Breastfeeding breaks

"The breast sometimes can be full and painful which may lead to migraines, and that can stop one from concentrating in class. The teacher should allow her to take breaks from school and go back to breastfeeding."

(IDI participant 7, parenting girl, 18-year-old)

Financial support

"I would like someone to help raise the baby, someone who can pay school fees, someone who can buy uniforms, books and such things.

(IDI participant 1, parenting girl, 15-year-old)

Childcare support

"Currently I don't have any fears. My major stress is this baby and the place where she would stay as I go to school. But if I can get someone to pay for my school fees and find a place where I could leave my baby I will not refuse to go back to school."

(IDI participant 16, parenting girl, 17-year-old)

Advice and encouragement

"For me, personally, I like people who motivate me and support me, not that one person who discourages me and insults me. With such a person, they make me lose morale and feel down. What I can say is that you should be motivating girls and creating time to talk to them."

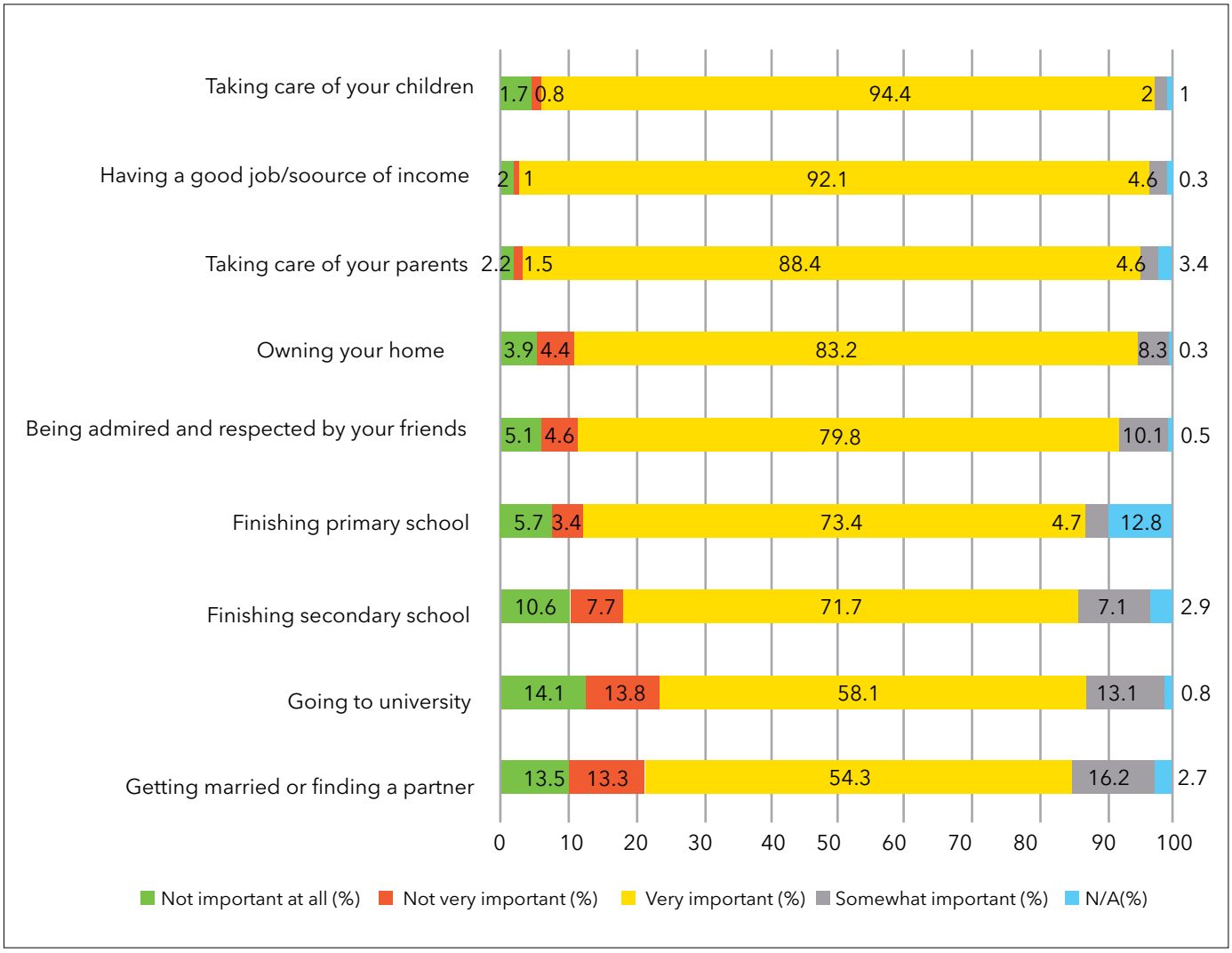
(IDI participant 17, parenting girl, 18-year-old)

Figure13: Main facilitators of school re-entry

Aspirations and expectations

Figure 14 summarizes the aspirations and expectations of pregnant and parenting adolescent girls. Most of them considered completing primary school (73.4%), secondary school (71.7%), and university education (58.1%) as very important. Further, most girls had high aspirations for owning homes (83.2%), taking care of their parents (88.4%) and children (94.4%), getting good jobs (92.1%), receiving friends' admiration and respect (80%), and getting married (54.3%).

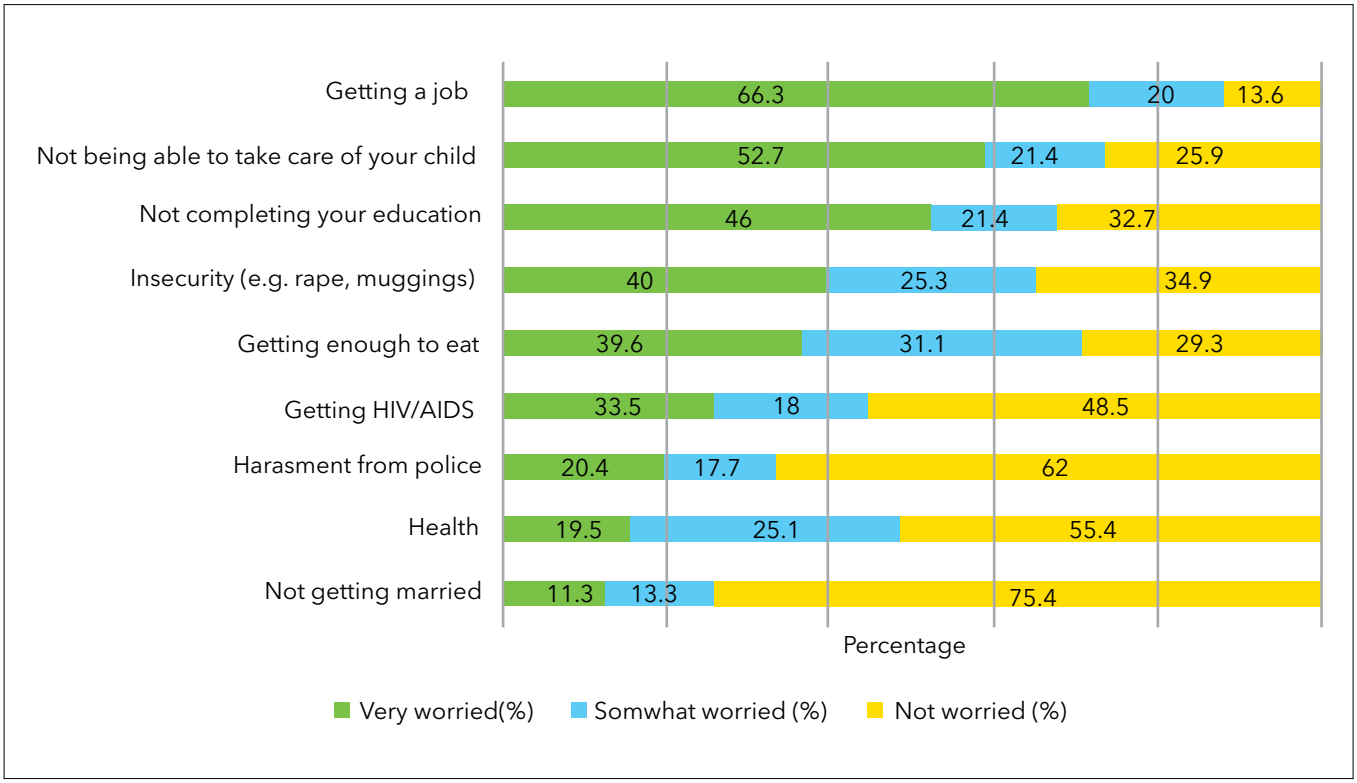
Figure 14: Aspirations and expectations of pregnant and parenting adolescents



Concerns of pregnant and parenting adolescents

Figure 15 shows that more than half of girls were worried about getting a good job (66.3%) and being unable to provide for their children (52.7%). Nearly half (46%) were worried about not completing their education. A substantial proportion of girls were concerned about having enough to eat (39.6%), as well as insecurity, rape, and muggings (40%). One third (33.5%) were concerned about contracting HIV/AIDS. Further, girls were least worried about their health (19.5%), being harassed by the police (20.4%), and getting married (11.3%).

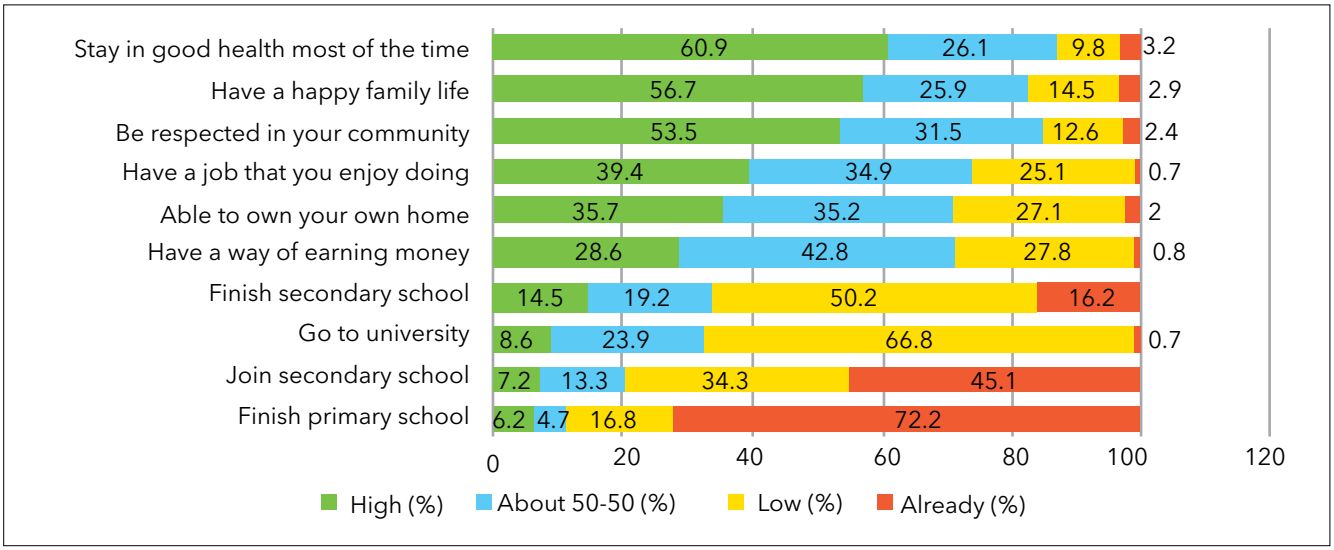
Figure 15: Concerns of pregnant and parenting adolescent girls



Perceived life chances

Figure 16 illustrates that most girls had already completed their primary school education (72.2% of 594), whereas less than one fifth (16.2% of 594 girls) had already completed their secondary school education. Notably, for most girls who dropped out of secondary school, 50.2% rated their chances of ever completing secondary education as low, with 14.5% indicating high chances. Among the 590 girls who had yet to enroll in the university, two thirds (67.3%) perceived their university entry chances as low, while 8.6% rated their chances as high. Meanwhile, 28.6% and 39.4%, respectively, rated their chances of earning money and acquiring a job they love as high. Slightly more than a third (35.7%) of the girls felt their chances of owning a home were high. More than half of the girls (56.7%) had high hopes for a happy family, and three fifths (61%) had high hopes for staying in good health most of the time. In addition, 53.5% had high expectations for being respected in their communities.

Figure 16: Perceived life chances of pregnant and parenting adolescents



Lived experiences of adolescent boys

As noted in the methods section, we interviewed 10 parenting adolescent boys about their own experiences. The interviews revealed that adolescent boys became fathers at an early age because they lacked accurate information about contraceptives and parental supervision, abused alcohol and drugs, and were curious about sex. Also, peer pressure pushed boys to engage in sex and made them at risk of early fatherhood. Becoming a father so early radically changed the lives of adolescent boys. Because adolescent fatherhood was frowned upon in the community, boys who got girls pregnant were gossiped about, ridiculed, jeered, and rejected. Adolescent fathers were labeled and referred to by the name of the girl they impregnated. Also, parents warned their sons not to associate with adolescent fathers. A boy stated:

> "When you meet your friends with their parents, they are being warned not to walk with [you], so you find yourself isolated and heartbroken."
>
> (IDI participant 7, parenting boy, 19-year-old)

Some community members supported adolescent fathers with baby items, but this only happened if the boy was living with his child's mother. Most adolescent fathers reported facing financial challenges and a lack of job opportunities. Consequently, they were unable to meet their parental obligations. Most of the adolescent fathers interviewed lived and depended on their parents/families for their daily provisions. However, they felt they have a responsibility to provide for their baby and the mother. Despite being unable to adequately fulfill this role, a few interviewees dropped out of school to get unskilled, low-paying jobs to meet this responsibility. Better-paying jobs were inaccessible due to their young age, lack of national identity card, low education attainment, and few or no skills. For a few who took full responsibility and resided with their partner and baby, lack of experience as a father made it challenging, especially when their child is sick. Most of the time, they did not know what to do or how to become the best father they can be. Although they wanted to get involved in the baby's life and take responsibility, they lacked enough resources to support their partner, baby, and family. This sometimes led to conflicts and mental distress. Some expressed that they started using drugs more than before to ease the pressure.

"There is a time I went job hunting, but I was not successful for the whole day, so I will have to think what will be eaten back at home and at that moment I have no money."

(IDI participant 6, parenting boy, 17-year-old)

"[I] find that most of the burden is on me, but I am trying. I am putting in more effort. The girl asks for a lot from me. I do struggle since in my job today you can get, the next day you lack."

(IDI participant 7, parenting boy, 19-year-old)

"I used to buy her fruits and sometimes, if I did some work, I would buy her clothes and take them to her. If I had some money like 100 shillings, I would give her mother to buy milk or bone soup for the girl. I also bought her nice dresses whenever I came across one."

(IDI participant 3, parenting boy, 18-year-old)

Those who lived together with their partner and baby also found other ways to assist, such as with house chores, babysitting, and moral support. However, a few did not provide any form of support because they could not see the child and no longer talked to the child's mother.

Becoming a father made the boys want to change their lifestyle for the better. Most of them wanted to be involved in the day-to-day life of their babies in the future. Despite dropping out of school, they wanted to raise children who would complete their education. They also desired to ensure that their children had good morals and that they would not lack basic needs. A few were determined to return to school to make something good out of their lives and help the girl return to school. The boys expressed their desires for support, such as employment or financial support to start a business. Some wanted to enroll in courses to learn new skills that would enable them to earn a living. The boys expressed the need for guidance and counseling services to help them cope as they experience fatherhood.

Conclusion

In this study, we examined the lived experiences of pregnant and parenting adolescents in Korogocho, an informal settlement in Nairobi. The study illustrates the socioecological factors that predisposed girls to early and unintended pregnancy. Lack of correct contraceptive knowledge and access, poverty, peer pressure, family conflict and breakdown, and lack of family support and supervision were the main factors associated with early and unintended pregnancy among adolescent girls in the study setting. While free maternal health care was available, many missed out on antenatal care, especially early in their pregnancy, due to fear and shame. A significant proportion of girls experienced mistreatment and abuse in health facilities during childbirth and were especially discriminated against because of their age. Adolescent pregnancy exacerbated mental distress among adolescent boys and girls. Despite their high aspirations to complete school, fewer than half of the girls intended to return to school. Key barriers to school re-entry include a hostile school environment, lack of childcare support, parental withdrawal of support, and poverty.

Recommendations

The recommendations highlighted in this report were informed by discussions during a validation meeting held with community leaders, parents, policymakers, and pregnant and parenting adolescents.

Preventing early and unintended pregnancies

Early and unintended childbearing in urban informal settlements is fueled by factors at all socioecological levels: individual, family, community, and structural. Given the complexities of these factors, we recommend that governments and their partners develop comprehensive programs that address the multiple determinants of adolescent pregnancies, including alleviating poverty and ensuring that young people have access to accurate sexual and reproductive health information and services to prevent both early and unintended pregnancies and repeat pregnancies among adolescent parents.

Access to maternal health care

This study shows that a vast majority of adolescent girls received antenatal care services. However, only a few initiated antenatal care early or completed at least eight visits. Fear, shame, and stigma made girls conceal their pregnancy and caused them to be reluctant to seek antenatal care services. During childbirth, girls reported mistreatment and abuse, including physical and verbal abuse, discrimination, lack of privacy, and detainment. Key stakeholders engaged during study validation workshops suggested the following to address these issues:

- Government should establish a youth-friendly special desk where cases of mistreatment and abuse in health facilities can be reported and addressed.
- Key stakeholders, including parents, community-based organizations, and government should provide psychosocial support for distressed pregnant and parenting adolescents.
- Health care providers, including nurses and midwives, should be trained to provide respectful and non-judgmental services to pregnant and parenting adolescents. Having youthful health care providers who are relatable to adolescents would also be beneficial.

Childcare

Adolescent mothers face difficulties in caring for their babies. The following are recommended to address these challenges:

- Establish low-cost daycare centers that adolescent mothers can afford.
- Establish safe houses for adolescent mothers in Korogocho where parenting adolescents can drop off their babies in the morning and pick them up in the evening.
- Encourage parents of pregnant and parenting adolescents to support adolescent parents with childcare.
- Incorporate cash transfers and daycare support as part of vocational training interventions.

Livelihood

Most pregnant and parenting adolescents were out of school, vocational training, or employment. This puts these girls at risk of cyclical poverty, with dire implications for their health and well-being and that of their children. The following are recommended to address these challenges:

- Governments and community-based organizations should provide vocational training opportunities for pregnant and parenting adolescents.
- Leaders such as members of the county assembly should introduce a bill to reduce vocational training fees in technical vocational education and training colleges.
- Government and parents should provide financial support for pregnant and parenting adolescents.
- Community-based organizations or non-governmental organizations should assist pregnant and parenting adolescents in setting up businesses.

Intimate partner violence

Close to half of the girls had experienced gender-based violence, and less than half of them (45.5%) sought help. Over half of girls who sought help (52.7%, n=131) did so from their own family, while 18.3% sought help from their partner's family. To improve access to gender-based violence services, the following are recommended:

- Government and community-based organizations should provide emergency toll lines for people to call and report cases of intimate partner violence.
- Government and community-based organizations should set up referral pathways to ensure the girls get help.

School re-entry

About two out of five pregnant and parenting girls desired to return to school but were unable to due to several challenges, including lack of childcare support, financial challenges, parental opposition to schooling, and a hostile school environment. The following are recommended to address these challenges:

- Government, through the Ministry of Education, should sensitize teachers and students to stop discrimination against parenting adolescents who return to schools and respect pregnant and parenting adolescents' rights to an education that is free of stigma and discrimination.
- Relevant stakeholders should provide financial support for school fees, school uniforms and books, and child upkeep.
- Schools should allow breastfeeding breaks for parenting girls.
- Grandparents can be supported to look after the babies while adolescent parents return to school.
- Parenting girls should avoid negativity from peers, parents, and the community.
- Members of county assemblies or parliament should provide bursaries for adolescent parents through the constituency bursary funds.

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