

# Teenage Pregnancy and Sexually Transmitted Infections in Selected Urban Schools: Compliance in Implementing School Health and Re-Entry to School Policy in Kenya

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**Abstract:** **Background:** Pregnancy-related and sexually transmitted infections (STIs) among teenage school girls contribute to significant morbidity and mortality in such a segment of the general global population. The Kenya National School Health Policy of 2022, 2018 & 2009 was developed to mitigate teenage pregnancy and facilitate continued pursuit of education post-pregnancy on a Return-to-School framework. The policy was expected to protect the girls from getting pregnant and support them if it occurred so as to enable them pursue their education on the basis of the Return-to-School Policy. However, despite this government led intervention, the extent of implementation of the National School Health Policy and its impact in reducing teenage pregnancies among girls in our schools has not been clearly documented. **Purpose of the Study:** This study was designed to determine compliance to the implementation of the re-entry policy on teenage pregnancy and health policy on sexually transmitted Infections in selected urban secondary schools in Kenya. The key objectives of this study were to identify the steps in the implementation of school health re-entry policy on teenage pregnancy and sexually transmitted infections. **Methodology:** This was an analytical cross-sectional study that triangulated quantitative and qualitative methods of study in 57 secondary schools that were co-education or girls' schools only. A sample size of 174 pregnant or previously pregnant school teenage-girls' was arrived at using Cochranes formular. Qualitative method was used to collect data on focus Group Discussions and Key Informant interviews. The target population consisted of school girls aged 15-19 years. Structured questionnaire was used to collect quantitative data. Multistage followed by cluster sampling techniques were used to identify selected urban towns for study while simple random sampling was used to identify girls or co-education schools. Teenage girls' participants were purposely identified at the health facility during antenatal care attendance until a sample size of 174 participants was achieved. The variables under study were then extracted and recorded from the card. **Data Analysis:** Quantitative data was analysed using SPSS version 17 while association between variables and hypothesis testing was done by Chi-square test at 95% confidence interval. Findings of Focus Group Discussion and Key informant Interviews were transcribed and analysed thematically, content by content. **Study Findings:** The study found out that the school Re-entry

implementation process had poor compliance by schools. Achi-square test of association set at 95% of confidence interval and 0.005 level of significance revealed that the responses the teachers and the affected students gave on its implementation were insignificant since the computed P-values (1.25 & 1.17) were greater than the set P-Value of 0.005. **Conclusions:** The re-entry policy was yet to succeed in schools. There was no compliance of the steps in the policy implementation. **Recommendations:** There is need to involve all stakeholders in all steps of the policy processes and sensitization of the same to all stakeholders.

**Keywords:** Teenage, Pregnancy, School, Health, Compliance, Implementing, Policy, Urban, Kenya.

## 1. Introduction

Teenage pregnancy and sexually transmitted infections rank globally among the top five to ten categories of conditions and diseases respectively which prompt teenagers and adults in developing countries to seek health-care services, with sub-Saharan Africa carrying the highest burden (Dehne, 2020). Indeed, the World Health Organization (WHO) report (2019) indicated that globally, young people aged 15 -24 years accounts for 70% of all gonorrhoea and chlamydia – all of which are sexually transmitted infections STIs with short- and long-term ramifications on their health, future productivity and career progression. These data prompted the Kenya government to act on mitigating teenage pregnancy and sexually transmitted infections in schools.

School health policy and its guidelines were then developed by the Ministry of Education in conjunction with the Ministry of Health, Public and Sanitation in 2009, revised in 2018 and provided new set of guidelines in the year 2022. The policy was meant to improve the health of school-age going children thus increasing their participation, retention, attendance, reduce absenteeism, improve their cognitive performance and transition rate in the education sector in order to help the country realize the millennium development goals, sustainable

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millennium goals, the country's vision 2030 and other related international goals. Eight thematic areas namely values and life skills; gender, growth and development; child rights and responsibilities; water, sanitation and hygiene; nutrition; disease prevention and control; special needs, disabilities and rehabilitation; school infrastructure and environmental safeguards formed the comprehensive school health policy document.

A re-entry policy was introduced under the thematic areas of gender, growth and responsibilities regarding pregnancy, Human Immunodeficiency Virus (HIV) and other sexually transmitted infection. The re-entry policy stated that a pregnant female learner, shall on discovery of pregnancy, be allowed to continue with classes for as long as possible and will be eligible for admission after delivery. Meanwhile the parents of the affected student are supposed to be counselled on the pregnancy, antenatal clinic attendance and medical examination by the school health teacher and matron or school nurse. The school is also supposed to share with the parents on information on circumstances leading to pregnancy and explore the possibility of taking legal action against the father of the child. After delivery, she was supposed to be allowed to go back or be given support to gain admission into another school if she felt there are issues of stigma and discrimination in the previous school. Upon re-admission, the student is supposed to be counselled again with emphasis on life-skills.

The policy further stated that students are supposed to undergo voluntary medical screening once per term as an early intervention against pregnancies and sexually transmitted infections. The school health policy was therefore meant to improve opportunities especially for girls to ensure equal access, retention, inclusion, equity and completion in both primary and secondary schools. This was further meant to help the Kenyan girl realize her full productive and academic potential that will in future enhance her meaningful contribution to Kenya's vision 2030 that emphasizes on production in various economic sectors of the country. The Kenya's vision 2030 acknowledges that improved health for young learners and through provision of universal primary and secondary education is a critical driver to the achievement of this vision especially in matters of poverty reduction.

The purpose of this study was therefore to determine compliance to the policy by the schools through identifying the steps in the implementation process of school health re-entry policy on teenage pregnancy post-delivery and sexually transmitted infections in the selected urban schools in Kenya.

## 2. Research Methodology

This study was carried out in eight (8) major urban settings distributed in eight former administrative regions of Kenya. The eight urban areas were Mombasa, Machakos, Nairobi, Nyeri, Nakuru, Kisumu, Kakamega and Garissa. Each administrative region provided one urban center for study. This was an analytical cross-sectional study that applied triangulated various methods of sampling techniques in 8 purposively selected urban settings. The 8 urban areas were chosen for study because they each had previous records of the highest number

and concentration of co-education and school girls in the region they represented in the study (BESB, 2016). Secondly, the major towns were reportedly as having a higher HIV/STI prevalence rate (2.2%) among young people aged 15 – 19 years compared to their rural counterparts of 0.5% (NASRHP, 2015). A sample size of 174 girls was arrived at for recruitment into the study using Cochran's formula of  $n = Z^2pq/d^2$ . The study was triangulated using multiple sources of data that consisted of 16 Focus Group Discussions (FGD) and 8 Key Informant Interviews (KII) and checklist questionnaires. The target population consisted of school girls aged 13-19 years, enrolled in form 1-4 who were then pregnant or had had a pregnancy in the course of their studies. Multistage cluster sampling was used to identify urban towns while simple random sampling was used to identify girls only or co-education secondary schools and the heads of the schools.

To determine compliance to the implementation process of the re-entry policy for pregnant teenagers by the schools, the study used the National School Health guidelines to develop the questionnaire. The head teachers or school health teachers were subjected to the questionnaire. The guidelines spelt the process of the re-entry policy implementation. As part of the process the head teacher or his assignee were asked whether the student and parents were counselled on discovery of pregnancy as well as on the need for medical examination and antenatal care for the pregnant girl. The study also delved into whether the school tried to find out the circumstances leading to pregnancy. The interview also wanted to find out if the student was allowed to continue with her studies on discovery of pregnancy and if she was re-admitted after delivery and done the necessary counselling on life skills. The study had initially had to seek from the schools if they were aware of the school-re-entry policy and its guidelines. The head teacher was expected to answer, 'YES' or 'NO'. Those who answered 'NO' were explained to about the policy. The responses were subjected to a chi-square test of association to determine if there was disparity between the actual or predicted data.

The pregnant or affected students were also asked similar questions only that they were expected to confirm if they were taken through the process of re-entry policy for pregnant school girls. Based on these questions, a chi-square test of association was also carried out to compare the observed and expected results of the study.

To determine if the schools subjected the students to voluntary medical examination at the beginning of every term, a questionnaire was developed for the same to address that section of the school health policy.

Similarly, a focus Group discussion was conducted for parents or guardians and heads of various secondary schools. The aim was to determine if they were aware of the policy, their opinion on the re-entry process and the expected impact on school teenage pregnancy. Key informant interview was also administered to experts in the areas of reproductive health from the ministry of health as well as to administrative education official experts from the ministry of education. Informed consent was taken from the participants before administration of any questionnaire.

Data for trends in teenage pregnancy for the past ten years (2014 -2023) in the sampled urban schools were obtained from the respective school health teachers or the principals of the schools to help determine if there was any mitigation progress in the policy. Data obtained from sampled schools of a given urban area was aggregated for each year to form a single data for the urban setting and treated as the trend for the area. The results were plotted as a graph in percentages for the ten (10) year period for the urban schools.

Informed consent was obtained from the participants before administration of a questionnaire, interview or any form of focus group discussion. The participants were explained to about the nature of research, benefits, risks and discomforts prior to administration of research data collection instruments.

This study was supported by supervisors from the University of Nairobi Institute of Tropical and Infectious Diseases (UNITID), college of Health Sciences of the university of Nairobi, the Kenyatta Hospital-University of Nairobi Research & Ethics Approval Committee and the National Commission for Science, Technology & Innovation through their issuance of research permit.

### 3. Research Findings

#### A. Distribution of Respondents by Geographical Location

Table 1  
Distribution of respondents by geographical location n=174

| Region        | County   | No. of Participants | Percentage (%) |
|---------------|----------|---------------------|----------------|
| Coast         | Mombasa  | 24                  | 13.8           |
| Eastern       | Machakos | 9                   | 5.2            |
| Nairobi       | Nairobi  | 75                  | 43.1           |
| Central       | Nyeri    | 12                  | 6.9            |
| Rift valley   | Nakuru   | 21                  | 12.1           |
| Western       | Kakamega | 8                   | 4.6            |
| Nyanza        | Kisumu   | 19                  | 10.9           |
| North Eastern | Garissa  | 6                   | 3.4            |
|               |          | 174                 | 100.0          |

Table 1 illustrates the distribution of the research respondents in the various selected urban areas of the study. Nairobi had the highest number of participants due to large volumes and number of schools. Garissa had the least number of girls

schools.

#### B. Demographic Data of Student Participants by Age Category

Table 2  
Distribution of respondents by age category, n=174

| Age Category | Frequency | Descriptive Statistics |
|--------------|-----------|------------------------|
| 13-14        | 10        | X-bar=16.99            |
| 14-15        | 15        | SD=1.54                |
| 15-16        | 19        | Se=0.116               |
| 16-17        | 25        | CV=9%                  |
| 17-18        | 45        |                        |
| 18-19        | 60        |                        |

Table 2 shows the social demographics of the respondents by age category. The mean age of the respondents stood at about 17 years with a standard deviation of 1.54, standard error of 0.116 and a coefficient variation of 9 percent. The majority of the participants fell within the 18 – 19 age bracket which can be attributed to rapid changes in individual exploration of body identity and sexual learning experiences. This is perhaps why the majority become victims of pregnancy and sexually transmitted infections. This This is perhaps why the majority become victims of pregnancy and sexually transmitted infections. This later stage of adolescents is commonly accompanied by high level sexual attraction, cognitive development, testing boundaries and breaking rules.

#### C. Head Teachers' Responses on Re-entry Policy Implementation Process

Table 3 shows chi-square test of association on teachers' response variables on re-entry policy implementation. The test was set at 95% confidence interval and at 0.005 level of significance. In comparing the results of the observed and the expected in responses, the P-value was found to be 1.25 which was greater than the set P-value of 0.005. This means the deviations between responses were insignificant and therefore the implementation process by the schools was defective. This study therefore rejected the process as being at variance with the school re-entry policy implementation process.

Table 3  
Chi-Square test of association on head teachers' response variables on Re-entry policy implementation process, n=57

| Return To School Implementation Policy | Counselling on Pregnancy | Background Information on Pregnancy | Allowed to Continue with Studies | Readmission after Pregnancy | Total       |
|--|--------------------------|-------------------------------------|----------------------------------|-----------------------------|-------------|
| yes                                    | 45                       | 30                                  | 3                                | 13                          | 91          |
| No                                     | 12                       | 27                                  | 54                               | 44                          | 137         |
| Total                                  | 57                       | 57                                  | 57                               | 57                          | 228         |
| DF                                     |                          |                                     |                                  |                             | 3           |
| CHI SQUARE (X2) =(O-E)^2/E             | 2.526315789              | 12.78947                            | 51.15789                         | 33.96491                    | 100.4385965 |
| P-Value                                |                          |                                     |                                  |                             | 1.2508E-21  |

Table 4  
Chi-Square test of association on pregnant students' responses on Re-entry policy implementation process, n=174

| Description                              | Response |     |     | Results (n=174) |
|--|----------|-----|-----|-----------------|
|  | Yes      | No  |     |                 |
| Performance Counselling on pregnancy     | 60       | 114 | 174 | 74.68966        |
| Brief information leading to pregnancy   | 60       | 114 | 174 | 74.68966        |
| Student allowed to continue with studies | 20       | 154 | 174 | 136.2989        |
| student re-admitted after pregnancy      | 44       | 130 | 174 | 97.12644        |
| TOTAL                                    | 184      | 512 |     | 382.8046        |
| DF                                       |          |     |     | 3               |
| CHI SQUARE (X2) = (O-E)^2/E              |          |     |     | 382.8045977     |
| P-Value                                  |          |     |     | 1.17381E-82     |

#### D. Pregnant Student Responses on Re-entry Policy Implementation Process

In determining if the implementation to re-entry process was adhered to by the participant pregnant girls, a chi-square test of association carried out on their responses. The test was set at 95% confidence interval and at 0.005 level of significance. In comparing the results of the observed and the expected in responses, the P-value was found to be 1.17 which was greater than the set P-value of 0.005. This means the deviations between responses were insignificant and therefore the implementation process by the schools was defective. The study therefore rejected the process as incompatible with the process.

#### E. Trends in School Teenage Pregnancy in 8 Urban Areas in Ten Year Period

Figure 1 indicates trends in teenage pregnancies from 57 co-education and girls' secondary schools in eight urban areas for a period spanning from 2014 to 2023. The figures indicate that there has been a gradual decline in school teenage pregnancy from 20% in 2014 to 10% in 2023. This compares well with the Kenya Demographic and Health Survey of 2022. According to the survey, teen pregnancy rates declined to 15% in 2022 from 18% in 2014. This could perhaps be attributed to the social dynamics created by Covid pandemic of 2020 to 2022 and the benefits of an introduced limited sexuality education in secondary schools for form three students.

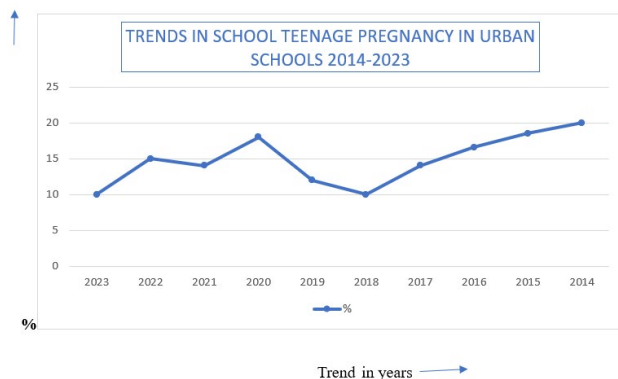


Fig. 1. Trends in school teenage pregnancy in the last 10 years, n=57

## 4. Discussions

The discussions in this chapter are based on the study findings that related to the study objectives, research questions, hypothesis, literature review and other related academic studies.

The purpose of re-entry policy was to address the high rates of school dropouts among the girls due to pregnancy and early motherhood. The policy was meant to ensure that the affected students are not permanently excluded from formal education and have the opportunity to complete their schooling. Contextually, teenage pregnancy refers to teens between the ages of 13 to 19 years who were pregnant or had had a pregnancy during the time of this research period.

Teenage pregnancy in secondary schools in Kenya is holding back the gains made as a result of the introduction of the Universal Primary Education (2003) and is also renegeing on our girls from maximizing their full academic potential as

productive future adults and citizens. Although this study found out that pregnancy rates in urban schools has been declining in the past ten years, the trends has not been very remarkable to demonstrate significant change of improvement. The study found out that there was a change from 18% to 12 percent from 2014 to year 2023 compared to the national figure of 18% to 15% (KDHS, 2023) for the same period). While school re-entry policy for girls after school pregnancy was meant to increase access to education and bringing social justice and equity in education, very little has been done in terms of social or community sensitization and mobilization over the issue of teenage school pregnancy. In African context, and especially among Kenyan communities, implementing the policy is a problem due to diverse perspective on the education from some communities on the education of the girl child. This can bring about lack of commitment on the ground in terms of community support for the policy.

This study found out that the mean age of the respondents stood at about 17 years with the majority of the participants falling within the 18 – 19 age brackets. This research attributed this to rapid changes in individual exploration of body identity and sexual learning experiences as the years progress from 13 to 19 year- tail end of teenagerhood.

The urban areas that participated in the study show that Nairobi (43.1%) followed by Mombasa (13.8%), Nakuru (12%) and Kisumu (10.9%) in that order of frequency recorded the highest number of school teenage pregnancies against the national pregnancy rate of 15% (KDHS, 2022). Garissa urban area recorded the least percentage of school teenage pregnancy.

The goal and the mandate of the National Adolescent Sexual and Reproduction Health Policy, NASRHP (2022) under the Ministry of Health is to enhance the sexual reproductive health of the adolescents in Kenya and to contribute towards realization of their full potential in National development. This mandate, according to the policy, extents to supporting sensitization and implementation of the education re-entry policy for schools' girls after delivery and even to offer social support systems for the victims of pregnancy. This was meant to also scale up social protection for vulnerable girls to delay sexual debut as well as improve their mental health and educational outcomes. This study argues that there is a weak link between mere presence of ministry of Health Policy and the implementation of the policies and the enforcement of the related laws in mitigating school girl pregnancies and promoting and enhancing the re-entry policy. Indeed, among the key roles of the NASRHP (2022) is to promote the provision of accurate information and services to prevent early and unintended pregnancies among adolescents in public and in school settings. This role, according to key informant interviewees and Group Focus Discussions in this study has not been adequately prosecuted in schools to mitigate pregnancies and enhance the school re- entry policy implementation. Though the reproductive health policy is a function of the national government, there lies an opportunity for progress in the devolved systems of government for its implementation in collaboration with schools. This can be done by counties generating data on school pregnancy from educational offices

data bank and use it to develop capacity in interventional decision making under the National reproductive Health Strategy (2016).

The trends in most African countries are to make it easier for pregnant school girls to continue with their education through use of the re-entry policy because of the realization that teen pregnancy has negative health, social, and economic consequences on girls and national development (KNCPD, 2022).

Interviews from the school heads or their assignees indicated that the officers got to know about the re-entry policy through the County educational offices or various circulars from the ministry of education. This study reminded them that there were two documents available on school health policy: The Kenya School Health Policy (2009, 2018 & 2022) and its sister guidelines. This meant that schools had never accessed the key documents but were implementing the policies on the basis of summarized official circulars. According to the Kenya School Health Policy document (2018 & 2022), all schools should, in their custody have, for reference in the course of discharge of their duties, *inter alia* the Kenya School Health Policy (2018). This information is contained in the annex five of the policy document. Several responses related to implementation process of the policy were elicited from the implementers. A chi-square test of association between the responses was carried out by this study. The study wanted to determine if the implementation to re-entry process was adhered to by the schools and the affected girls. The study found out that the deviations between the responses were insignificant for both the students and the teachers and therefore the implementation process by the schools was defective. The study, therefore rejected the process as policy non-compliant.

There are several interventions that address teenage pregnancies in Kenya. These includes the Children Act (2002), Sexual Offences Act (2006), Prohibition of Female Genital Mutilation (2011) and the Constitution of Kenya (2010). The Return-to-school Policy (2022, 2018, 2009) and the National Adolescent Sexual and Reproductive Health Policy (2015) draw their strength from the four instruments. The re-entry policy allows girls to return to school after childbirth while the reproductive health policy supports the provision of Youth Friendly Services (YFS) to young persons with the aim of empowering and facilitating them to make the right choices pertaining to their sexuality through removing obstacles that impede their participation in social and economic activities by setting up youth friendly services in the country. The reproductive health policy implementers seem to have abdicated their overall responsibilities by failing to participate in the activities of the re-entry school health policy.

Policy makers and implementers in the Group Focus Discussions and Key Informant Interviews in this study argued that implementation of the re-entry policy can only succeed if in its design, development, implementation and monitoring and evaluation involved all stake holders particularly parents. Those from the ministry of health held the view that the department of family health had the mandate to participate in all health activities of the school.

## 5. Conclusion

The aim of this study was to explore the implementation of the re-entry policy for girls after teenage pregnancy in selected urban secondary schools in Kenya. The study also aimed to qualitatively present the voices of the policy formulators and implementors from the ministries of health and education through Focus Group Discussions and Key Informant Interviews forum in order to give them an opportunity to narrate their experiences with school health policy. Finally, the study explored new effective ways that could be adopted for policy implementation on the basis of new findings. The findings of this study, therefore, were intended to contribute to the improvement in implementation of the re-entry policy, the reduction of teenage pregnancies and the mitigation of sexually transmitted infections among teenage girls in urban secondary schools. The conclusions of the study are as under:

The study revealed that all the sampled schools had never accessed the actual policy document on National school health Policy and its guidelines. The teachers therefore lacked the necessary adequate knowledge and understanding on re-entry policy. The understanding lacked clarity, was conflicting and confusing among teachers, heads and education officials.

Secondly, schools and the ministry of education are yet to succeed with the school re-entry policy because studies have shown that only 16% of girls who took maternity leave from schools re-enrolled after childbirth in 2021. This is supported by evidence gathered from FGD and KII in the study.

Fourthly, mitigation against teenage pregnancy and improvement in enrolment through the re-entry policy process in schools require the use of ministry of health structures in collaboration with the grass route communities and the ministry of education at policy formulation level and implementation.

Finally, the study rejected the null hypothesis on the basis that the variables that were being tested for the hypothesis were statistically significant using chi-square test of association.

## 6. Recommendations

- 1) Grass root communities and all other stakeholders be involved in designing, developing and implementing the school health re-entry policy. Taking the conversation to the local community would assist the implementing agents to understand the difficulties of implementing a national policy in a local context. The policy should be inclusive.
- 2) The Government through the ministries of education and Health to develop a National comprehensive Sexuality Education program that will address the sexual needs and reproductive rights of the Youth in order to mitigate against teenage pregnancy, improve re-entry policy and reduce sexually Transmitted infections.
- 3) The ministries of Health in collaboration with Education should mount a sensitization and awareness program to the policy among all communities and stakeholders. The message should pay attention to the language used, be non-judgmental but should reflect its intent which is to encourage girls to go back to school post-delivery and this must be monitored and reviewed regularly.

- 4) The ministries of Education and Health should ensure that all policy documents, touching on issues of schools, which are formulated and processed must be availed to all schools, parents and other stakeholders.

### 7. Suggestions for Further Studies

This study suggests that further research needs to be carried out in the following areas on school health and re-entry policy:

- 1) Survey on introduction of National Comprehensive sexuality and Reproductive Health Education in secondary schools in Kenya.
- 2) Parents Inclusivity in designing, developing and implementation of Secondary school Re-entry Policy for post-delivery mothers.

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