Journal of
Health, Medicine and Nursing
(JHMN)

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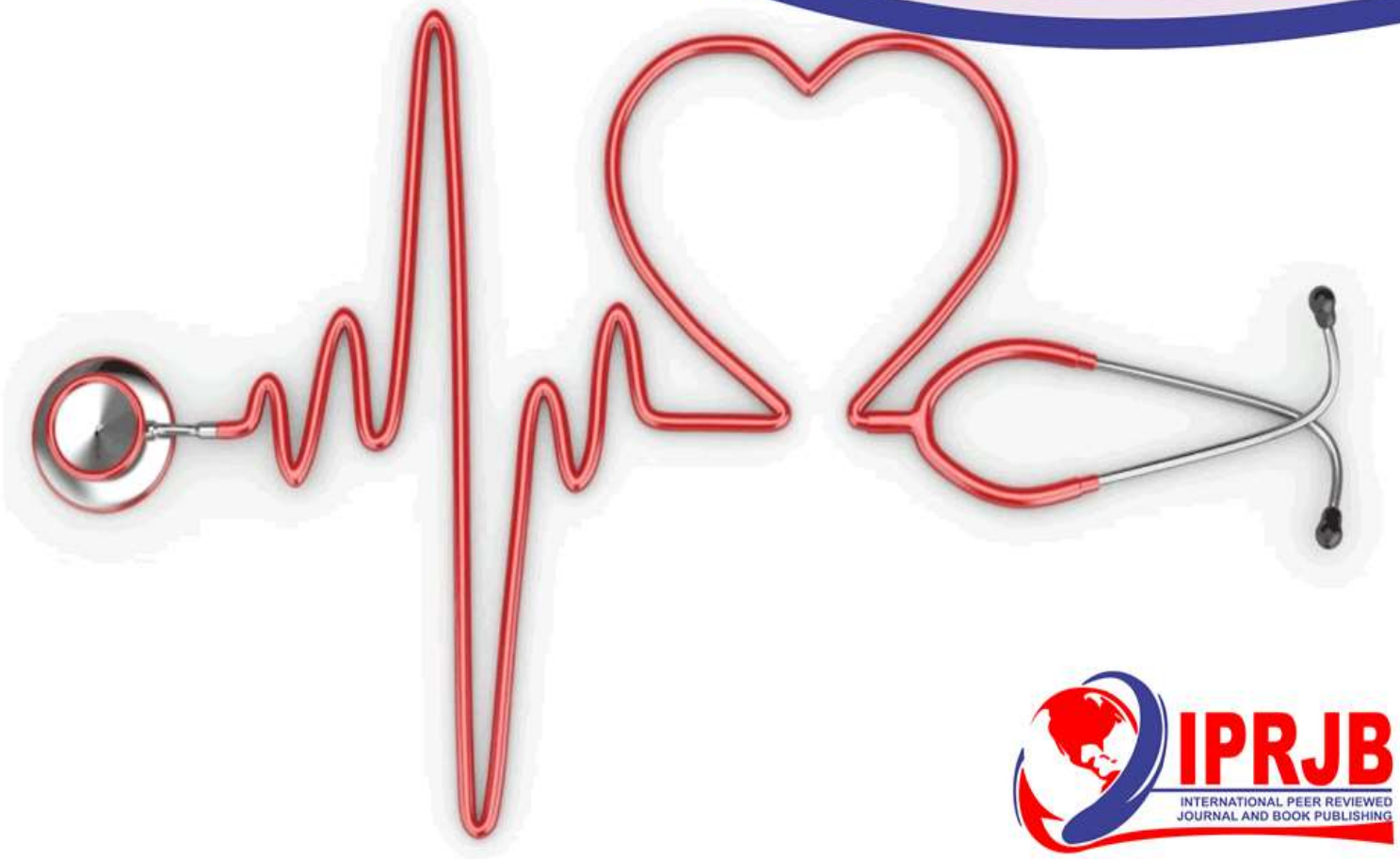

IPRJB
INTERNATIONAL PEER REVIEWED JOURNAL AND BOOK PUBLISHING

Journal of Health, Medicine and Nursing
ISSN 2520-4025 (Online)
Vol.10, Issue 4. No.1, pp 1 - 19, 2024

www.iprjb.org

Opportunities for Reproductive Health Programs in the Implementation of Schools Re-Entry Policy on Teenage Pregnancy and Sexually Transmitted Infections: Case of Selected Urban Schools in Kenya

Kishasha Meshack Kijungu[1]
Post Graduate PhD Student, Institute of Tropical & Infectious Diseases, University of Nairobi

[2]Samuel Mwangi Thumbi PhD, MSc. BVM
Professor of Epidemiology & Infectious Diseases, University of Nairobi & Washington State University

[3]Alloys S. S. Orago PhD; DSc; MSc; MPH; Bed/Sc; MBS
Full Professor of Clinical Immunology & Epidemiology of Infectious Diseases, School of Medicine, Kenyatta University

[4]Miriam C. A. Wagoro PhD; PGDIP; MScN; BScN
Doctor of Clinical Bioethics & Intn'l Research Ethics Specialist, University of Nairobi, School of Nursing Sciences

Article History

Received 13th June 2024

Received in Revised Form 18th July 2024

Accepted 26th August 2024

How to cite in APA format:

Kijungu, K., Thumbi, S., Orago, A., & Wagoro, M. (2024). Opportunities for Reproductive Health Programs in the Implementation of Schools Re-Entry Policy on Teenage Pregnancy and Sexually Transmitted Infections: Case of Selected Urban Schools in Kenya. *Journal of Health, Medicine and Nursing*, *10*(4), 1–19. https://doi.org/10.47604/jhmn.2893

Abstract

Purpose: This study was designed to determine the opportunities available for the ministry of health as the custodian of reproductive health programs on mitigating teenage pregnancy and sexually transmitted infections in Kenya.

Methodology: This was an analytical cross-sectional study that triangulated various sampling techniques. Based on unmitigated increase number of school pregnancies and sexually transmitted infections, the study obtained information on opportunities available to introduce and implement reproductive health program from the specialists in the ministries of health and education using Focus Group Discussions, Key Informant interviews and questionnaires techniques. A total of 16 respondents was realized using the standard saturation point method. Multistage followed by cluster sampling techniques were used to identify selected urban towns. A sample size of 174 school-female teenage participants female were tested for pregnancy and sexually transmitted infections in the eight urban areas. Analysis of data was done by use of descriptive statistics, Analysis of Variance (ANOVA) and content analysis.

Findings: The study found out that the ministry of health through the National Sexual and Reproductive Health Policy and its strategic plans had not taken up the opportunity to perform its role of supporting re-entry policy and reproductive health education in schools. Although the Ministry of health, through its established organs had a role to play in mitigating Teenage Pregnancy and Sexually Transmitted infections, it had not put structures in place for its implementation in schools.

Unique contribution to Theory, practice and Policy: The ministry of health needs to support school-entry policy as part of its mandate. Successful programs and policies require the involvement of all stakeholders in designing, developing and implementing and must be inclusive and well resource supported. The findings of this study need to be appraised by the policy makers and implementers for fresh and improved interventions.

Keywords: *Challenges, Opportunities, Teenage, Pregnancies, School, Health*

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 gonorrhea 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 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 infections. 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 students are supposed to be counseled 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.

This study relied for its theoretical framework on the Health Belief Model (HBM). This is a public health issue which is in tandem with the philosophy of HBM.

This theoretical model was developed in 1950's by social psychologists Kurt Lewin, Hoch Baum, Rosenstock) who were working in the United States Public Health services. The model was developed to explain and predict the lack of public participation in the health screening and preventive programs. The principal tenet of the model was that people cannot participate in health programs until they perceive the problem at hand as posing a threat to their lives. Elvis (2015) explains that this model is the most commonly used theory in the study of public health programs. He opines that the model stands out distinctly as one of the firsts that fully address human behavior's relating to the phenomena of health-promotion. Even in the contemporary times, like-minded social psychologists argue that it remains one of the most widely recognized conceptual frameworks of health behaviors.

The Health Belief Model (HBM) is the most appropriate theory to be used in this study. Saunders (2012) explains that this model is the most commonly used theory in the study of public health programs such as teenage pregnancy and sexually transmitted infections whose solutions require change in health promoting behavior. The health belief model has special impact on public behavior regarding public health programs. The theory states that people will alter their behavior if they perceive that they are susceptible to a negative health condition resulting from the behavior, that the condition resulting from behavior must be of severe nature to make them change for as long as they possess the necessary resources for mitigation. This theory is therefore applicable to sexuality education programs that aim to prevent teenage pregnancy and sexually transmitted infections, HIVs and AIDS, in secondary schools. The strength of this theory is that it can help educators, policy makers and implementers to improve individual and public health by tackling barriers to good health, improving knowledge and helping to motivate action.

The purpose of this study was therefore to determine available opportunities for ministry of health under the mandate of reproductive health programs to help mitigate against the rising teenage pregnancies and sexually transmitted infections in schools using the Ministry of Education school re-entry health Policy on teenage pregnancies in Kenya.

Statement of the Problem

Teenage pregnancy and child birth is a major global problem (WHO, 2022) with an estimated 21 million girls aged 15 -19nyears in developing countries becoming pregnant and 12 million giving birth per year. WHO report of 2022 found out that such teenage pregnancies are usually accompanied by life threatening conditions such as hypertensive diseases, abortions, high maternal mortality and school drop outs as compared to child bearing mothers who are above 24 years of age. Socially, many of the pregnant school girls face several difficulties such as rejection or experience violence from partners, parents and even peer groups. In Kenya, 18.8% of the teenagers experience a pregnancy, a situation that threatens the achievements of the sustainable Millennium Development Goals (2015) and the country's vision 2030 since this age group is a key contributor to the realization of these goals (KNASRHP, 2022). The KNSHP (2018) recognizes that improved health for teenagers without the interruption by pregnancy, enhances cognitive development, concentration, participation and retention of children in school. It also reduces absenteeism and school drop outs; increases enrolment and improves academic performance which are necessary tools in enabling the youth to help the country achieve the goals of vision 2030. Despite this policy, a large body mass of adolescent s (18%) still drops out of school even when it is stipulated in the policy (Chandra, 2013). Therefore,

effective implementation of school health policy on teenage pregnancy will go a long way in the realization of Kenya's vision 2030 as espoused in the KNSHP (2018).

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 girls' schools 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. Data on socio-demographics of the pregnant or those who had had a pregnancy was collected mainly on age, urban distribution, sexually transmitted infections, contraceptive use, outcomes of pregnancies and trends of pregnancies in schools.

The study then engaged Key Informant interviews (KII) and Focus Group Discussions (FGD) from the ministries of Health and Education which was conducted by the trained research assistants between 27th November 2023 and 26thth February 2024 across the eight urban areas. During the interviews, health and education professionals were asked if they were aware of any school health and return-to-school health policy on teenage pregnancy and sexually transmitted infections in Kenya. Those who could mention any policies and programs were asked further to describe those policies and programs by mentioning some of their key strategies/activities. Those who could mention any of these were probed further to describe the programs. The respondents were further asked to explain if any measures have been taken to mitigate against the same in schools.

The interviews took place in educational school offices, ministry of health buildings and private offices based on participants' preference. The interviews were conducted in English. A total of eight KII were conducted. The interviews lasted between 30- and 60-min. They were audio-recorded and professionally transcribed and analysed through content analysis Similarly, eight groups of Focus Group Discussions (FGD) consisting of 8 members were also conducted and each of recordings were transcribed and analysed by content analysis. Informed consent was obtained from both KII and FGD participants after they had been fully informed about the aim of the study, its procedures and all possible risks.

In trying to answer the research question on identification of opportunities in the policy implementation for reproductive health programs on teenage pregnancy and sexually transmitted infections in schools, the study further designed a questionnaire for the same reproductive health and educational officials working at the policy level of the ministries of health and education respectively. The respondents were purposively selected for the study.

The questionnaire covered at least one official from each of the eight urban settings thus bringing a total of 16 respondents from both ministries. The questionnaire was set on a three Likert scale of: Agree, Disagree or Not sure thus requiring the respondent to state any one of them for each statement. The study analysed the responses in terms of percentages and then subjected the various responses to analysis of variance in order to determine for Significant differences on responses on opportunities for introducing reproductive health programs in schools.

The study then subjected the various responses that required ''Agree, disagree or Not Sure'' on the various testable variables to Analys of Variance (ANOVA). The main purpose of the ANOVA was to determine if there was a significant difference between the mean of the variables under study on opportunities for introduction of various interventional measures on pregnancy and sexually transmitted infections in schools. The variables included sex health education in schools, equiping schools with family planning facilities, undertaking medical examination and pregnancy tests and STI screening, counseling and testing for HIV in schools or public health facilities for students set at 95% confidence interval.

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.

FINDINGS

The research findings are based on the objectives of the study

Geographical Distribution of Teenagers in the Selected Schools

Table 1 illustrates the distribution of the teenage 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.

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
Total		**174**	**100.0**

Distributions of the Teenage Student by Age Category

Table 2 below 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.

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	

Student Participants on Previous Use and Type of Contraceptives

The information on previous use and type of contraceptive by the study participant was collected from the data available in the respondent antenatal card at the health facility and entered into the data base. Table 3 shows the differentials in the use of contraceptives use by method as captured from the 174 respondents. Slightly over a quarter (34.5%) of the students used emergency contraceptive method which was apparently the preferred method. This was followed by oral combined pill at 28.7 percent and the natural family planning (23%) which was in essence the most popular traditional method. The teens tended to popularly use emergency pill perhaps because they did not, prior to sex intercourse, plan for protected intercourse or do so when they are caught up in a situation of sexual assault without contraceptive coverage.

Table 3: Previous Use and Type of Contraceptives by the Respondents, n=174

Contraceptive/Method	Number of users	Percentage users
Oral contraceptive pill	50	28.7
Intrauterine Device (IUD)	0	0
Contraceptive patch	0	0
Contraceptive Implant	1	0.6
Contraceptive injection	2	1.1
Diaphragm	0	0
Condom (male partner)	16	9.2
Natural F/P	40	23
Emergency pill	60	34.5
Other: sterile, pull out, Ring	5	2.9
Total		**100%**

Prevalence of HIV among Student in the Selected Urban Population

Prevalence was calculated by dividing the total number of students who were tested positive for HIV by the total number of female students in the respective urban area multiplied by a hundred percent. The total population of the school girls from the eight urban areas was

419,353. The total population for each urban area is indicated in the table(BES, 2023). The sample size and the number that tested positive for HIV from the respective area are also indicated as shown in the table below. The results were obtained from 174 female students using their antenatal cards in the eight urban areas at their health facility of attendance. Informed consent was obtained from all respondents after they had been fully informed about the purpose of the study, its procedures and all possible risks.

Table 4: Prevalence of HIV among Girls in Urban Areas (School- Base Population)

Urban Area	Total School Population	Sample Tested	Sample Tested Positive	Prevalence
Mombasa	18324	24	4	0.022
Machakos	63913	9	5	0.008
Nairobi	54639	75	15	0.027
Nyeri	40003	12	5	0.012
Nakuru	84880	21	7	0.008
Kakamega	96287	8	5	0.005
Kisumu	52661	10	4	0.008
Garissa	8646	6	1	0.012
Total	**419353**	**165**	**46**	**0.102**

Demographic for student participants on pregnancy outcomes

Table 5 below indicates the number of participants who had experienced various pregnancy outcomes during the course of the study. Pregnancy outcomes were rated as post maturity, full time live birth, preterm live pregnancy, late still birth, early still birth, spontaneous abortion, induced abortion and death. Post maturity pregnancy is one that goes beyond a gestational age of 42 weeks while a full term one is between 40 to 42 weeks of gestation. An early still birth is one that occurs between 20 to 27 weeks as compared to a late still birth at 28 to 36 gestational weeks of pregnancy. Abortions, whether spontaneous or induced are defined as loss of pregnancy before 20 weeks of gestational age.

Normal pregnancy is expected to culminate into good obstetric outcomes of a live baby at term. The table below provides evidence that 40 percent of the pregnancies ended as term live birth while 60 percent resulted into either complication of abortions, preterm, death and post maturity. Eight four students, at the time of data collection, had pending pregnancy outcomes.

Table 5: Pregnancy Outcomes for the Respondents, n=174

Pregnancy outcome	No. of Participants	Percentage (%)
Post--datism (post maturity)	4	2.3
Term- live Birth	36	20.7
Preterm-live birth	18	10.3
Early-Still Birth	7	4.0
Late-Still Birth	14	8.0
Spontaneous Abortion	3	1.7
Induced Abortion	6	3.4
Deaths	2	1.1
Pending Outcomes	84	48.3
Totals	**174**	**100.0**

Journal of Health, Medicine and Nursing
ISSN 2520-4025 (Online)
Vol.10, Issue 4. No.1, pp 1 - 19, 2024
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Incidental Tests for Sexually Transmitted Infections in Students Antenatally

Table 6 below shows data of the teenage pregnant mothers who attended antenatal clinics for routine laboratory tests in the eight selected urban areas of study. During antenatal examination they were incidentally found to have features related STI other than HIV, VDRL meant for routine tests. They were investigated after having taking consent for the laboratory procedure. The results were reflected in their antennal record cards.

The results indicate that the prevalence is highest in Nairobi followed by Kisumu, Nakuru, Mombasa, Kakamega, Nyeri, Machakos and Garissa in that order of frequency. These results can be interpreted that the chances of being infected with STI's by a female student is likely to be highest in Nairobi as compared to other urban settings of this study. Nairobi needs more public health interventions on the issue than even Garissa.

Table 6: Laboratory Results of Incidental Tests, n=174

Region	No. of Participants	No Tested Positive	% prevalence
Mombasa	24	6	3.45
Machakos	9	2	1.15
Nairobi	75	25	14.37
Nyeri	12	3	1.72
Nakuru	21	7	4.02
Kakamega	8	4	2.30
Kisumu	19	9	5.17
Garissa	6	1	0.57
Total	**174**	**57**	**32.76**

Trends in School Teenage Pregnancy in 8 Urban Areas in Ten-Year Period

Figure 4.1 below 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.

Journal of Health, Medicine and Nursing
ISSN 2520-4025 (Online)
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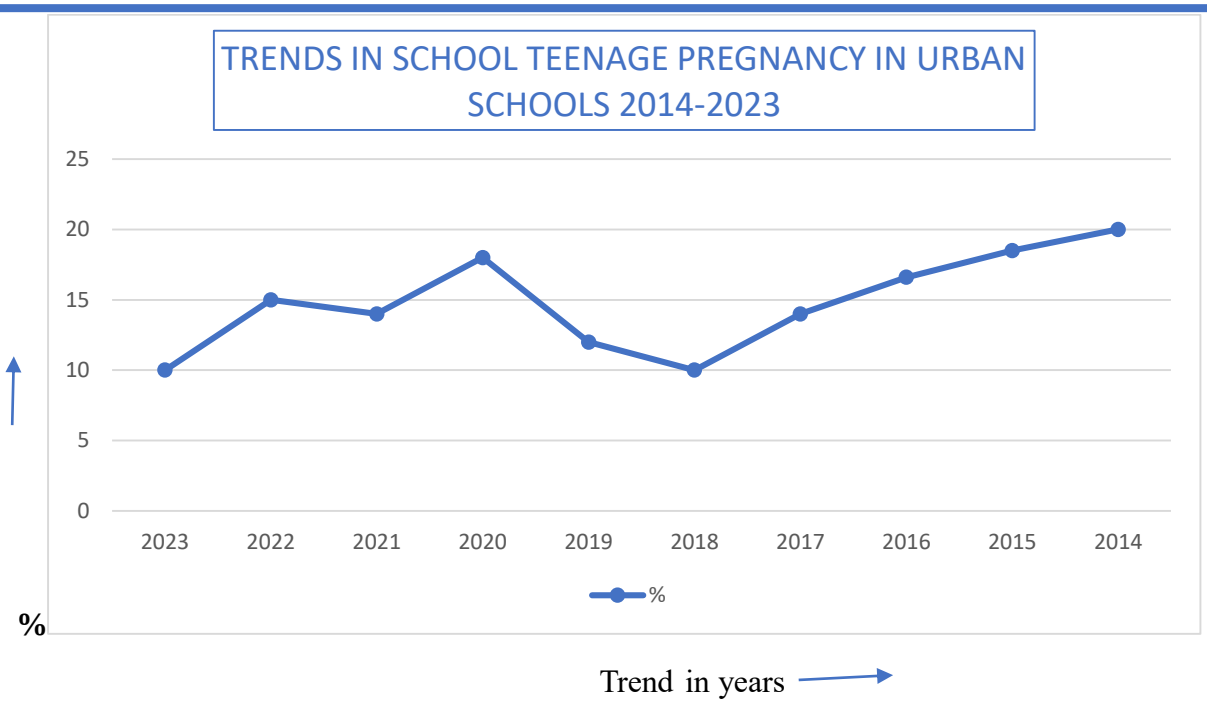

Figure 1: Trends in School Teenage Pregnancy in the Last 10 Years, N=57

Opportunities for Reproductive Health Programs on Re-entry Health Policy

Table 7: Respondents in Providing Health Education to Teenagers in Schools, n=16

Types of Respondents	No of Responses	% Percentage
Agree	15	94
Disagree	1	6
Not sure	0	0
Total	**16**	**100**

The results showed that many of the respondents (96%) were of the opinion that health education should be provided to teenagers in schools to create awareness on matters of sexuality.

Table 8: Respondents on Opportunity to Equip School Clinics with FP Facilities, n=16

Types of Respondents	No. of Respondents	% percentage
Agree	7	44
Disagree	7	44
Not sure	2	13
Total	**16**	**100**

The results showed an equal tie (44%) by the participants as to whether family planning health facilities should be introduced in schools as part of mitigating teenage pregnancy. Forty-four (44%) of the respondents agreed to introduction of family planning practices while another 44% disagreed on the same issue. The import of these results is that the problem is quite controversial among parents and professionals and that it requires consensus building among stakeholders.

Table 9: Opportunity to provide-Youth Friendly services & ASRH at schools, N=16

Types of Respondents	No. of Respondent	Percentage %
Agree	12	75
Disagree	3	19
Not sure	1	6
Total	**16**	**100**

The results showed that 75% of the respondents were able to see the opportunity to introduce Youth Friendly health services in schools and health facilities as a result of an increase in teenage pregnancy in schools. This denotes that the magnitude of the problem needed a different approach that requires teenagers' participation in the planning, implementation, monitoring and evaluation of sexual reproductive health services and programs that addresses fully their needs in an appropriate manner.

Table 10: Opportunity to Justify Conducting Medical Exams Pregnancy & STI's Screening n=16

Types of Response	No. of Respondents	Percentage %
Agree	10	63
Disagree	4	25
Not sure	2	13
Total	**16**	**100**

Many of the respondents saw an opportunity to have a justification for the schools to conduct medical examination for pregnancy and STI screening in schools. This is possibly to help evaluate the health status of the students, screen for risk factors and diseases and provide preventive counseling interventions especially for sexually transmitted infections.

Table 11: Responses on Opportunity to Provide Counseling & HIV Testing Services for n=16

Types of Responses	No. of Respondents	Percentage %
Agree	9	56
Disagree	5	31
Not sure	2	13
Total	**16**	**100**

Fifty six percent (56%) of the respondents discerned the opportunity for schools to provide counselling and HIV testing services to students. This percentage is not overwhelmingly high for it seems many respondents were not for the idea. Perhaps the thought of stigmatisation and psychological trauma it can cause to peoples chidren was high in their mind.

Testing for Significancant Differences using ANOVA for Opportunity Responses

The ANOVA findings in table 3.12 showed that the computed F-ratio of 8.0051 is higher than the critical F-table value of 3.885 meaning that variations among responses is more than is expected to be seen by chance. This indicates that the between-group differences in variables being tested were statistically significant at P-value of 0.006 set at 95% confidence interval. Therefore, in such an occurence as in this study, the null hypothesis was rejected.

Table 12: ANOVA for Significant Differences on Responses on Opportunities

Subjects	Agree	Disagree	Not Sure	ANOVA Findings
1	15	0	1	
2	6	9	1	
3	14	0	2	
4	10	5	1	
5	6	9	1	

Findings of ANOVA

SUMMARY				
Groups	**Count**	**Sum**	**Average**	**Variance**
Agree	5	51	10.2	18.2
Disagree	5	23	4.6	20.3
Not Sure	5	6	1.2	0.2

ANOVA						
Source of Variation	**SS**	**df**	**MS**	**F**	**P-value**	**F crit**
Between Groups	206.5333	2	103.2667	8.005168	0.006183	3.885294
Within Groups	154.8	12	12.9			
Total	**361.3333**	**14**				

2020 t0 2022 and the benefits of an introduced limited sexuality education in secondary schools for form

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 Selected Urban Areas

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 reneging 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.

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. This study show that Nairobi 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.

Normal pregnancy is expected to culminate into good obstetric outcomes of a live baby at term. This study assessed the various outcomes for the teenage pregnancies in the selected urban schools. The study noted that 40 percent of the pregnancies ended as term live birth while 60 percent resulted into either complication of abortions, preterm, death and post maturity thus signifying a serious teenage pregnancy outcome. The import of this data is such that teenage pregnancies must be avoided because they are accompanied by several poor obstetrical and gynaecological outcomes and other maternal life-threatening conditions such as abortions.

Contraceptive Use and Teenage Pregnancies

The teens tended to popularly use emergency pill perhaps because they did not, prior to sex intercourse, plan for protected intercourse or do so when they are caught up in a situation of sexual assault without contraceptive coverage.

Teenage Pregnancy and Prevalence of Sexually Transmitted Infections

In this study the pregnant teenagers who showed signs and symptoms of other sexually transmitted infections other than the routine ante natal laboratory tests, were subjected to further examinations. The results indicate that the prevalence was highest in Nairobi followed by Kisumu, Nakuru, Mombasa, Kakamega, Nyeri, Machakos and Garissa in that order of frequency. These results can be interpreted that the chances of being infected with STI's by a female student is likely to be highest in Nairobi as compared to other urban settings of this study. Nairobi needs more public health interventions on the issue than even Garissa. Further results showed that Mombasa urban area had the highest prevalence of HIV from pregnant teenage school girls followed by Garissa based on student population distribution. The import of the results was that the chances of contracting HIV from a secondary school female student in Mombasa schools was higher than the other mentioned urban area.

Opportunities for Introducing Sex and Reproductive Health Programs in Schools

The results on teenage pregnancies and sexually transmitted infections in selected urban secondary schools in Kenya is a serious indicator for introduction of national sex and reproductive health programs in schools as a key intervention tool.

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.

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).

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.

Teenagerhood is part of an adolescent stage in which girls experience sexual growth and development that brings health challenges to their lives and general well- being. Most importantly, they become vulnerable to early unplanned pregnancies during their school lives as a result of these developments. To mitigate against the unplanned pregnancies and create support for the Re-entry School Health policy, there is need to use multi-pronged approach that uses existing health structures that support the initiatives. These structures include the Adolescent Sexual and Reproductive Health Policy.

Although there is a slight decline in teenage pregnancy in schools for the past 10 years (KBS,2022), there is still need to address the endemic issue to bring it to acceptable international levels. The findings of this study indicate that family planning among school girls

is live in schools. The study found that despite lack of education on contraceptives in schools, 34.5% of the participants used pills at one time and yet experienced a pregnancy while 28% used combined oral contraceptives. The import of these findings is that there is an opportunity and need to introduce comprehensive sexual education as a national program to tame teenage pregnancy and to facilitate re-entry school policy. The best placed institution to deliver the program is the ministry of Health through its Adolescent and Sexual reproductive health programs. In fact, the mandate of the ASRH (2022) program as per their strategic plans are to support the provision of Youth Friendly services through the school health programs. According to the Kenya constitution (2010), every person has the right to the highest attainable standard of health, which includes the rights to health care services. One such right is to introduce sexual and reproductive health services in schools that will address the contraceptive perspectives of teenagers. In any case, a key strategy of the ASRH policy is to incorporate adolescent sexual and reproductive health education into curricula of all education and training institutions and to provide education to parents and the community on the sexual and reproductive health rights of the adolescents and the Youth.

There are several benefits of officially introducing family planning and medical examination as part of the national comprehensive sexual and reproductive health program in schools. This is to protect the teenagers from physical, emotional and financial burden of unplanned pregnancy. Secondly, it is to protect teenagers from sexually transmitted infections and its future body consequences through early detection of the treatable infections. Thirdly, it will help to identify any early signs of health issues in school children as well as evaluate health status, screen for risk factors and disease, and provide preventive counselling interventions.

The research findings indicate that 94% of the ministry of health and that of education policy makers and implementers found it quite challenging to introduce sexuality and reproductive health education in schools yet it is within their purview. Similarly, 81% found it yet challenging to initiate Youth Friendly health services in schools yet results indicate that the prevalence of school teenage girls is quite demonstrable as well as the magnitude of sexually transmitted infections among the pregnant groups. The implementers and policy makers are the custodians and harbingers of the appropriate information necessary to the youth. These challenges can be overcome by using the policy instruments to provide education to parents and the community on sexual and reproductive health and rights of the adolescents by the process of sensitization and building consensus. One of the strategies contained in the National Adolescent sexual and reproductive health plans (2021) is to strengthen the capacity of teachers, parents and leaders within communities to provide appropriate information on HIV/AIDS and sexually transmitted Infections. This strategy needs to be strengthened in order to help the policy implementers meet challenges of empowering the youth through the intended school programs. In that way, the re-entry school policy will succeed as well as the mitigation of teenage pregnancies in schools.

This study has given a reflection of the burden of teenage pregnancy and the trajectory of the sexually transmitted infections in selected urban schools in the form of prevalences among teenage girls in eight major towns of Kenya. Indeed, despite a 90-100% transition of girls from primary to secondary by girls, access, retention and completion due to teenage pregnancies and sexually transmitted infections remain a challenge to the Kenya educational system. The purpose of re-entry was to provide a framework of enhancing re-entry for learners who dropped

out of school in order to improve retention, transition and completion rates for secondary education.

Teen pregnancy is not a troubling problem in Nordic countries because the countries have powerful healthcare systems to warrant conducting a non-judgmental approach and support for the teenagers (Honig, 2012). Kenya has very good legal and policy instruments and structures that can support a reduction in teenage pregnancy, STI's and enforce the re-entry school policy for pregnant girls after delivery. According to Maurine (2022), schools were yet to succeed with re-entry policy because only 16% of girls who took maternity leave from schools re-enrolled after childbirth in 2021.

The role and responsibility of the Ministry of Health, through its instruments of the National Adolescent Sexual and Reproductive Health policy and Health strategy, is to support sensitization and implementation of the Education Re-entry Policy and social support system for adolescents as well as strengthening and scaling up social protection for vulnerable girls to delay sexual debut in addition to improving their mental health and educational outcomes. This can be achieved by the health ministry through mobilizing and allocating resources for Adolescent Sexual Reproductive Health Programs. The resources can be used to develop human resource capacity, equipping schools with Youth Friendly Health services, developing and implementing comprehensive sexuality education as a national program in schools and within communities. These activities can be supported by development partners. A well-coordinated comprehensive national sexuality education in schools, hopefully, will have the capacity to reduce and offer protection against teenage pregnancy, mitigate against cases of sexually transmitted infections and improve on the utilization of the re-entry policy in schools.

Introduction and implementation of Youth Friendly Health Services in schools under a comprehensive national sexuality program, can be an effective way of increasing utilization of health services by the teenagers and adolescents. A standard YFHS ensures accessibility and quality of care, privacy, confidentiality and information and counselling for students which is the hall mark of a good youth program.

This study reveals a concerning lack of awareness and understanding of the school health policy and its guidelines. Indeed, it was clear that the documents were not available in schools. The findings from the study also demonstrated the intricacy of this particular educational problem and this pointed out to the controversies the focus group discussion and key informant interview was able to provoke based on the many conflicting views as to its value and implementation process. The Kenya School Health Policy (2022) has a very good governance structure stretching from the ministry of Education in collaboration with the Ministry of Health up to the student or pupil council. This structure is very important because it brings in the meaningful participation of teenagers in the planning, implementation, monitoring and evaluation of school health services and programs meant to address their Sexual Reproductive Health needs. This is also meant to ensure that their needs are addressed fully and in an appropriate manner. However, the political support required to drive and champion the re-entry policy on teenage pregnancy is wanting. The ministry of education responsibilities, inter alia, is coordination of school health stakeholders, conduction of pre-entry and school screening as well as dissemination of information on school health matters including policy documents. There is a lacuna in information dissemination in schools and the parent community on the same. From this perspective, this study is of the view that more emphasis should be placed on stakeholders' participation especially parents and communities and resource mobilization and

allocation by the ministry of health in order to create a successful implementable school re-entry policy.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The aim of this study was to explore the opportunity for implementation of the re-entry policy for girls after teenage pregnancy in selected urban secondary schools in Kenya through the ministry of health established structures. . The study also aimed to qualitatively and quantitatively present the voices of the policy formulators and implementors from the ministries of health and education for 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:

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 policy makers and the findings in the study.

Thirdly, 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.

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.

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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