Situational analysis on early and unintended pregnancy in Eastern and Southern Africa

February 2018
UNESCO Education Sector

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### Acronyms

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<tr>
<td>AFHS</td>
<td>Adolescent-friendly health services</td>
</tr>
<tr>
<td>AYFS</td>
<td>Adolescent- and youth-friendly health services</td>
</tr>
<tr>
<td>AfriYAN</td>
<td>African Youth and Adolescents Network</td>
</tr>
<tr>
<td>ALHIV</td>
<td>Adolescents Living with HIV</td>
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<tr>
<td>ASRH</td>
<td>Adolescent sexual and reproductive health</td>
</tr>
<tr>
<td>ASRHR</td>
<td>Adolescent sexual and reproductive health and rights</td>
</tr>
<tr>
<td>AYSRHR</td>
<td>Adolescent- and youth sexual and reproductive health</td>
</tr>
<tr>
<td>CBDA</td>
<td>Community-based distribution agents</td>
</tr>
<tr>
<td>CHAZ</td>
<td>Churches Health Association of Zambia</td>
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<tr>
<td>CRHE</td>
<td>Centre for Reproductive Health and Education</td>
</tr>
<tr>
<td>CSE</td>
<td>Comprehensive sexuality education</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organization</td>
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<tr>
<td>CSTL</td>
<td>Care and Support for Teaching and Learning</td>
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<tr>
<td>DBE</td>
<td>Department of Basic Education</td>
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<tr>
<td>DSD</td>
<td>Department of Social Development</td>
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<tr>
<td>DHS</td>
<td>Demographic and health survey</td>
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<tr>
<td>ECD</td>
<td>Early childhood development</td>
</tr>
<tr>
<td>EDSEC</td>
<td>Education and Training Sector</td>
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<tr>
<td>EMIS</td>
<td>Education Management Information System</td>
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<tr>
<td>ESA</td>
<td>Eastern and Southern Africa</td>
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<tr>
<td>EUP</td>
<td>Early and unintended pregnancy</td>
</tr>
<tr>
<td>FAWE</td>
<td>Forum of African Women Educationalists</td>
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<tr>
<td>FAWEMA</td>
<td>Forum for African Women Educationalists in Malawi</td>
</tr>
<tr>
<td>FAWENA</td>
<td>Forum for African Women Educationalists in Namibia</td>
</tr>
<tr>
<td>FAWEZA</td>
<td>Forum for African Women Educationalists in Zambia</td>
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<tr>
<td>FBO</td>
<td>Faith-based organization</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
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<tr>
<td>GBV</td>
<td>Gender-based violence</td>
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<tr>
<td>Global Fund</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>HCW</td>
<td>Health care worker</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and communication technology</td>
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<tr>
<td>KII</td>
<td>Key informant interview</td>
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<td>LSE</td>
<td>Life Skills Education</td>
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<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
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<tr>
<td>PPAZ</td>
<td>Planned Parenthood Association of Zambia</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MESVTEE</td>
<td>Ministry of Education, Science, Vocational Training and Early Education</td>
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<tr>
<td>MHM</td>
<td>Menstrual Hygiene Management</td>
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<tr>
<td>MIS</td>
<td>Malaria Indicator Survey</td>
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MiET  Media in Education Trust
MICS  Multiple Indicator Cluster Survey
MoCTA  Ministry of Chiefs and Traditional Affairs
MoE  Ministry of Education
MoEAC  Ministry of Education, Arts and Culture
MoET  Ministry of Education and Training
MoEST  Ministry of Education, Science and Technology
MoGE  Ministry of General Education
MoGECW  Ministry of Gender Equality and Child Welfare
MoH  Ministry of Health
MoHSS  Ministry of Health and Social Services
MoHCDGEC  Ministry of Health, Community Development, Gender, Elderly and Children
NAPPA  Namibia Planned Parenthood Association
NIDS  National Income Dynamics Study
NGO  Non-governmental organization
NPO  National programme officer
PSA  Public service announcements
PTA  Parent-teacher association
RTHD  Research and Training for Health and Development
SADC  Southern African Development Community
SAfAIDS  Southern Africa HIV and AIDS Information Dissemination Service
SAT  Southern African AIDS Trust
SBCC  Social and behaviour change communication
SDG  Sustainable Development Goal
SNYC  Swaziland National Youth Council
SOP  Standard operating procedure
SRH  Sexual and reproductive health
SRHR  Sexual and reproductive health and rights
STI  Sexually transmitted infection
TACAIDS  Tanzania Commission for AIDS
UBOS  Uganda Bureau of Statistics
UNDP  United Nations Development Programme
UNFPA  United Nations Population Fund
UNESCO  United Nations Educational, Scientific and Cultural Organization
UNICEF  United Nations Children's Fund
WHO  World Health Organization
YFHS  Youth-friendly health services
YRBS  Youth Risk Behaviour Survey
YWCA  Young Women's Christian Association
Introductions

Early and unintended pregnancy (EUP) is a global public health concern. Extremely prevalent in sub-Saharan Africa, it is driven by multiple factors, including poverty, lack of information and access to reproductive health services, cultural norms, peer pressure, and sexual coercion and abuse. Among other negative consequences for adolescent girls, including for their health, social, and economic outcomes, EUP jeopardizes educational attainment due to school drop-out and decreased school completion. Preventing EUP is therefore an important component of a wider response to ensuring the right to education for all girls, requiring an effective response from the education sector in collaboration with other sectors.

Concern for sexual and reproductive health and rights (SRHR) and EUP has been widely expressed throughout the Eastern and Southern African (ESA) region by governments, United Nations (UN) agencies and the non-governmental organization (NGO) sector. Importantly, the Eastern and Southern African Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People (henceforth the ESA Commitment), endorsed and affirmed by ministers of health and education from 21 countries in the region in 2013, aims to scale up comprehensive sexuality education (CSE) and sexual and reproductive health (SRH) services for adolescents and young people in the region. Notably, the ESA targets include reducing EUP by 75% and integrating CSE curricula in 90% of schools by 2020. UNESCO and partners responded by developing a EUP campaign which aims to extend the ESA Commitment and accelerate the achievement of ESA targets. Addressing EUP is a key development intervention that will directly contribute to the Sustainable Development Goals (SDGs) of 2016, in particular Goal 3: Good Health and Well-being; Goal 4: Quality Education; and Goal 5: Gender Equality. The campaign will seek to reduce EUP through increasing awareness on its consequences, improving CSE delivery, promoting consistent condom use, and increasing access to and use of effective contraception for sexually active young people.

This document reports on a situational analysis that was conducted by Research and Training for Health and Development (RTHD) consultants from September to December 2017 to inform the EUP campaign development.

The situational analysis was commissioned to achieve the following objectives:

- Present the latest data on the magnitude of EUP and the impact on girls’ education in the ESA region;
- Provide an analysis of policy and programme responses to EUP in 10 ESA countries;
- Review relevant legislation in the selected countries, based on a recent United Nations Population Fund (UNFPA) study;
- Develop specific recommendations for improving country responses to EUP.

Methodology

The situational analysis included Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe and consisted of three components:

1. **A desk review** in all 10 countries of relevant legislation, policies and programmes, as well as of recent literature and online quantitative datasets. The most recent Demographic and Health Surveys (DHS) were used for the quantitative data review in all countries except Swaziland, where the DHS was outdated and the Multiple Indicator Cluster Survey (MICS) dataset was used instead. Early childbearing was analysed by rural/urban residence, education level, and economic status for each country, while data on sexual activity and use of modern contraception among 15–19-year-olds were reviewed by marital status. The literature review used Medline and Popline databases, and included published articles and unpublished reports from the 10 countries, focusing on the last five years.

2. **Qualitative field work** in four of the countries (Malawi, Uganda, Lesotho and South Africa) consisting of key informant interviews (KIIs) and focus group discussions (FGDs) using semi-structured interview guides. Between four and six KIIs were conducted in each of the four countries with officials from the Ministries of Education, Health, Youth or Gender, representatives of civil society/NGOs, and community-based stakeholders, including school principals and Life Skills teachers. Four FGDs were conducted in each country (two in urban and two in rural areas), where groups were segmented into young mothers, out-of-school girls over the age of 18, and parents/adult community members. Except for in Uganda, where translators were recruited, the FGDs were conducted in the language of the respondents. With permission from participants, the discussions were audio-recorded, and then transcribed verbatim and analysed thematically.

3. **National stakeholder dialogues** in the remaining six countries (Kenya, Namibia, Swaziland, Tanzania, Zambia and Zimbabwe), which followed the same objectives, agenda, and format across countries based on an open-ended dialogue tool. The objectives were to: (i) understand the national policy and programmatic response to EUP in the country; (ii) understand the education sector response to EUP (including provision of quality CSE and implementation of re-entry policies); (iii) understand linkages (referral system) between schools and health services in enhancing adolescent access to the health and education services; and (iv) understand the forms and impact of stigma and discrimination on pregnant and childbearing girls in schools and communities. Dialogues were held as half-day workshops with stakeholders from government and civil society organizations (CSOs), youth representatives, community health and social workers, and teachers and parents. The dialogues were carefully documented so that the reports could be used for the regional analysis and integrated into country level summaries.
Data from the desk review, quantitative and qualitative analyses, and dialogues were triangulated to verify findings and assess the consistency of the data.

**Findings**

A great deal of commonality emerged across the 10 countries’ related drivers, consequences and responses to EUP.

**Magnitude of EUP**

The percentage of young women aged 15-19 years who had been pregnant was high in all countries – at least 15% according to DHS data, and more than 25% in Malawi, Tanzania, Uganda and Zambia. Furthermore, there is evidence that teenage pregnancy has not decreased over time; rates have either stabilized or increased. For example, DHS data demonstrates that in Malawi, pregnancy rates have increased from 26% in 2010 to 29% in 2016, in Namibia, rates rose from 15% in 2006 to 19% in 2013; and in Uganda, rates increased from 23.8% in 2011 to 24.8% in 2016.

**Drivers and determinants**

In the ESA region, early pregnancies are more common in rural areas, among girls with low education levels, and those that are from the poorest households. Poverty is a key driver because teenage girls are able to obtain money and material goods that would otherwise be unaffordable through relationships with older men, who give them basic goods and/or gifts in exchange for a sexual relationship.

“Some girls leave school because of various problems they encounter at home. Some lack soap, exercise books, etc. because their parents do not have money. As a result they drop out of school to get married hoping to find peace at their own home and hoping that the husband will be buying things like soap. And in search of these things some girls are impregnated because they go out there looking for men who can assist them with basic needs.” – Rural out-of-school female youth FGD, Malawi, November 2017

In several countries in the region, particularly in rural areas, child marriage is a cultural norm that both leads to and results from adolescent pregnancy. Some parents are said to force their girls into early marriage to relieve themselves of the burden of taking care of the girls and to benefit from receiving bride price.

“Sometimes the child can have a mind of continuing with school, but the parent forces the child to enter into marriage because of poverty... Another problem is lack of understanding on the part of the parents of the benefits of educating girls. Most parents just think that when a girl reaches puberty they should be relieved of her and send her to marry so that they should also get something out of it.” – Rural parents’ FGD, Malawi, November 2017

In some rural communities, cultural practices such as initiation ceremonies further encourage girls to have early sexual debut and early marriage. Child sexual abuse, sexual coercion and/or sexual assault are additional important drivers of early pregnancy.

Through the review of DHS dataset indicators, the situational analysis found evidence of lack of access to and use of modern contraception among young women aged 15-19 years despite high levels of sexual activity. For example, in Malawi, while 64% of young women in this age group are sexually active, only 15.2% use modern contraception, while in Tanzania and Zambia, only 33% and 18% of unmarried sexually active women respectively use modern contraception. This points to a widespread lack of SRH services for youth. In addition, judgemental attitudes among health care workers, and in some instances parents, undermined contraception use. Abortion, often unsafe, emerged as an important form of pregnancy prevention among adolescent girls, who were not able or willing to access contraception.

Peer pressure and experimentation were reported to play a strong role in early sexual debut as well as intergenerational sex, since the pressure was both to have sex and to acquire resources such as clothes, and fancy hairstyles. Relationships with older men therefore helped girls to keep up with their peers both in terms of sexual experience and possession of material goods that their parents were not able to fund.

“I think that girls from the age of 12 are very vulnerable to older men because since I don’t have pocket money to go to school... A guy comes to me and tells me... he’s going to buy me jeans... they come and look at you ‘your hairstyle...!’ and even when I look at my next door neighbour I actually thought this guy is making sense because I will only sleep with him once and I will get the hairstyle and I’ll be just as good as my neighbour.” – Rural out-of-school female youth FGD, South Africa, December 2017

Lack of parent-child communication about sexual health issues, and parents’ resistance to adolescents accessing contraception, aggravates the risk of EUP in many settings.

“I don’t support it (contraceptives). I speak to the girl and advise her to abstain, but I can’t come out and say that I support her to go take contraceptives.” – Parents’ FGD, Uganda, December 2017

**Stigma and discrimination**

Teenage pregnancies were highly stigmatized in all countries and across all settings, notably schools and communities. The full responsibility for the pregnancy is assigned to the girl, while the male partner may deny involvement, reject the girl, and even, in some cases, be affirmed by peers and his community for his masculinity. Girls on the other hand, are considered bad examples and are very often ostracized and shamed both at school and in their communities. In extreme cases, they are shunned by their families and, in the context of bride price expectations, are considered a loss. In several countries, derogatory terms for pregnant teenagers exist such as “ogegere” (“second hand” in Uganda), “ntchembere” (“child-bearing woman” in Malawi), and “Gicokio” in Kikuyu language (“a reject”) in Kenya. At school level, pregnant girls experience negative attitudes from teachers and learners alike, and are frequently expelled, even if this is not national policy.
“Pregnant girls are often considered a bad influence in their communities. They are shunned, viewed as deviant, and negatively labelled by society and in their communities. They are perceived as promiscuous; they are victimized and referred derogatively to as ‘mvana’ (a young person having a child out of wedlock) or ‘nzenza’ (a good for nothing/useless person).” – Zimbabwe National Dialogue, 14 December 2017

“... because at school they will have expelled you (when you are pregnant)... (when you go back after giving birth)... they look at you like a bad influence, saying that how can you get pregnant in our school, and you are back again? And you are shaming the school.” – Urban out-of-school female youth FGD, Uganda, December 2017

Consequences

In addition to physical consequences, including higher risk for maternal deaths and illness, girls may undergo abortion which, in the majority of countries, is likely to be unsafe, putting her life at further risk.

“Stigma might also lead to unsafe abortion. When one hears those humiliating things about her they resort to abortion. And this is a challenge on its own as we often go to back street abortions and die.” – Urban out-of-school female youth FGD, Lesotho, December 2017

The emotional impact from EUP is significant, particularly if the girl has been rejected by her partner, family and community. Long-term risks include depression and substance abuse, and the majority of pregnant girls in the region do not complete school and/or have poor school performance, plunging them further into the intergenerational poverty cycle.

“They go through pain because most of the times they are rejected by the one who impregnated them, so the girl goes through emotional pain thinking why she did it. Plus during pregnancy, you require so many things which the girls don’t have most of the time. They go through emotional pain because they are ridiculed by their peers.” – Rural out-of-school female youth FGD, Malawi, November 2017

School drop-out is a major negative outcome for teenage mothers, even if re-entry policies are in place. This is because parents and communities are not aware of these policies, and heads of schools may either apply their own guidelines developed at school level, and/or use their personal discretion, authority and values to prevent re-entry. Even if re-entry is an option, girls are still vulnerable to drop-out since the school environment is often hostile and unsupportive.

Policy responses

Regional level policies have demonstrated commitment to decreasing EUP in ESA; notably, as mentioned, the ESA Commitment’s aim of reducing EUP among young people by 75% by 2020. Additional regional policy documents designed to align to the ESA Commitment are the Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region (2015); and the SADC Parliamentary Forum Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016).

Although, as the following table demonstrates, appropriate policies for EUP prevention and management are in place or in development in the majority of countries, the major weakness, regardless of the presence of policies, lies in implementation – particularly at local and school levels. At national level, countries are at varying stages of drafting learner pregnancy management policies with specific guidelines. In some cases, such as in Kenya, Malawi and Zimbabwe, policies are still in the form of a circular, hence re-entry guidelines are being developed. No standalone re-entry policies currently exist in Lesotho or Swaziland.

“While the general policy and legislation in the country is strong, the main challenge highlighted is the lack of proper implementation. There is a need for more training and awareness, comprehensive inspections, increased human resources, enhanced accountability and coordination.” – Namibia National Dialogue, 4 December 2017

“Policy implementation is weak and lacks community awareness and implementation frameworks/guidelines.” – Kenya National Dialogue, 5 December 2017

In some countries, relevant policies, such as age to consent to marriage, are additional barriers to preventing EUP. For example, in Tanzania and Namibia, girls can consent to marriage at 15 years. A lack of legislation for youth to access contraception is a further limitation. Only in Uganda, South Africa and Malawi is there legislative provision for adolescents to have access to SRH services. The absence of legal provision for adolescent girls to use SRH services remains a structural barrier to contraception use, and hence an important driver of EUP.

Comprehensive sexuality education

Countries usually offer CSE at schools through Life Skills Education (LSE) to varying degrees, and in different ways. CSE at primary school level is often integrated into several subjects in addition to Life Skills, commonly Science and Social Studies in South Africa and Namibia (Grades 4-7), it is offered as part of Life Skills, while in Tanzania, national dialogue participants indicated that elements of CSE have been introduced in the curriculum from Grades 1-7 through carrier subjects, and more materials are being developed. At high school level in Kenya, Swaziland, Malawi and Namibia, CSE is offered as part of Life Skills and integrated into other subjects, and in Zambia, it is integrated into several subjects. In Lesotho, on the other hand, it is a standalone subject for Grades 7-10, and in South Africa, it is offered through Life Orientation, which is compulsory and examinable from Grades 8-12.

LSE/CSE is therefore a key programmatic response in the education sector, and includes age-appropriate topics such as growth and development, identity, SRH, gender, HIV and AIDS, assertiveness, self-awareness, sex and sexuality, decision-making and problem-solving, peer guidance, interpersonal relationships, and drug and substance abuse. The teachers interviewed for this situational analysis therefore considered Life Skills not just a mere subject, but supports the development of healthy behaviours and decision making.
The following table shows a summary of policy responses by country.

<table>
<thead>
<tr>
<th>Country</th>
<th>Learner pregnancy management policies / guidelines / circulars</th>
<th>Policy practice</th>
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| **Kenya**   | • Re-entry of pregnant girls circular (1998)  
• Draft national re-entry guidelines in Basic Education (2017)                                                           | • Re-entry                                           |
|             | • Continuation where health permits                                                                                        | • Continuation based on other laws and policies       |
| **Lesotho** | • No standalone re-entry policy                                                                                            | • Re-entry                                           |
|             | • Ministry of Education Science and Technology Re-admission Policy (1993) Circular                                           | • Re-entry                                           |
|             | • Revised Re-entry Policy in draft form (2017)  
• School Re-admission Guidelines (2006)                                                                                       | • Re-entry                                           |
| **Malawi**  | • Education Sector Policy for the Prevention and Management of Learner Pregnancy (2009)                                      | • Re-entry                                           |
|             | • Re-entry                                                                                                                  | • Continuation                                       |
| **Namibia** | • National Learner Attendance Policy (2011)  
• Draft National Policy on Prevention and Management of Learner Pregnancy (2016)                                              | • Re-entry                                           |
| **South Africa** | • No standalone re-entry policy                                                                                          | • Mostly girls are allowed re-entry                  |
|             | • Re-entry                                                                                                                  | • At the discretion of local education authorities   |
| **Swaziland** | • Presidential directive to expel girls who fall pregnant (2017)  
• Draft re-entry guidelines, yet to be approved                                                                             | • Expulsion                                          |
| **Tanzania** | • No standalone re-entry policy                                                                                            | • Re-entry, expulsion or suspension – often at the discretion of the head teacher |
| **Uganda**  | • No standalone re-entry policy                                                                                              | • Re-entry, suspension – often at the discretion of the head teacher |
|             | • Guidelines for Prevention, Mitigation and Management of HIV and Teenage/Unintended Pregnancy in School-settings of Uganda (2015) | • Re-entry                                           |
| **Zambia**  | • Ministry of Education re-entry Policy (1997)                                                                               | • Re-entry                                           |
|             | • Re-entry                                                                                                                  | • Continuation                                       |
| **Zimbabwe** | • Ministry of Education Circular P35 (1999): Discipline in Schools: Suspension, Exclusion and Corporal Punishment          | • Re-entry                                           |

“I want to think that LBSE (Life Skills-based sexuality education) is a single stride in the right direction in preventing EUP” – High school Life Skills teacher, Lesotho, 23 November 2017

“Life Orientation covers all topics that can help them make informed decisions when it comes to pregnancy and prevention of it.” – Urban Life Orientation teacher, South Africa, November 2017

Teacher training efforts in CSE and SRH are underway in the ESA region, for example, in Uganda, Lesotho, Malawi, Zambia and Namibia. These initiatives have demonstrated some collaboration among the education, health and CSO/NGO sectors, and teachers felt that this training equipped them with basic skills to counsel students on SRH issues.

While Life Skills is offered in various different ways in schools and teacher training programmes are underway, CSE content may be diluted and, where the subject is not examinable, it may be de-prioritized. In some cases, teachers are uncomfortable and/or unskilled to discuss sexual health issues and may hold religious beliefs that inhibit their involvement in LSE. As a result, some teachers may refuse to teach the subject or may dilute the content by omitting some topics they deem unfit for students at a particular level, particularly sex-related topics. Key informants emphasized the need for teacher selection and training in Life Skills that addresses SRH issues of youth.

“Even though it is part of the school curriculum it has not been fully implemented. No specific teacher is assigned to teach it, it’s part of science subject; teachers shy off; others have no capacity to teach the subject; and most importantly there are competing priorities for examinable subjects.” – Kenya National Dialogue, 5 December 2017

“In terms of CSE in schools, there should be teachers who are well trained on SRH and not just to teach the knowledge they have obtained from the science textbooks.” – Tanzania National Dialogue, 18 December 2017
CSO/NGO interventions

Across the region, numerous CSOs and NGOs run programmes aimed at keeping girls in schools and preventing EUPs. These programmes have included visiting schools to talk to teachers and learners about SRH and developing manuals to guide girls and teachers on EUPs.

“FAWEZA (Forum for African Women Educationalist in Zambia) trains teacher mentors to work mostly with rural guidance and counselling teacher mentors to provide information on the support a re-entering child will need in school” – Zambia National Dialogue, 20 November 2017.

Programmes, however, do not reach all corners of the countries due to resource and other logistical constraints. There are many cases of CSOs collaborating effectively with governments to address EUPs in the countries under study, although these relationships are sometimes affected by poor coordination and in some cases general suspicion that CSOs are introducing culturally inappropriate practices.

Linkages and inter-sectoral collaboration

At national level, the importance of collaboration between key sectors such as Health, Education and Social Development was noted and the benefits of such collaboration were seen where the Ministries of Health/CSOs led training of teachers in SRH. However, weak intersectoral collaboration and CSO partnerships hamper progress in some countries.

For example, in Malawi it was reported that government and CSO collaboration was weakened by concerns that CSOs promote Western, donor-driven development agendas. Resistance to CSE among some communities and parents are additional barriers to progress.

The importance of strengthening linkages between schools and SRH services at community level was identified, particularly by national dialogue participants. In some communities, mapping high schools to clinics are opened when learners are in school and closed when learners are not in school is needed to facilitate referrals, however, the persistence of abstinence messaging at school level in many settings is at odds with the benefits of such collaboration where the Ministries of Health/CSOs led training of teachers in SRH.

“Ministry of Education does not have a mandate to distribute condoms but linkages need to be made with Ministry of Health so that they can provide youth friendly ways of providing condoms as this falls under their mandate” – Zambia National Dialogue, 30 November 2017

“Schools and clinics must develop a mechanism that will ensure that services are accessible. Referrals are taking place but the system needs to be strengthened, let’s have a tested model that is efficient, traceable and manageable. At the moment we are experiencing a situation where clinics are opened when learners are in school and closed when schools are closed.” – Swaziland National Dialogue, 7 December 2017

School level support

School level support to teenage mothers who manage to return to school is variable. In some cases structures are in place, including counsellors, peer educators and mother groups. The extent and effectiveness of these were not assessed.

Conclusions and recommendations

This situational analysis has confirmed that EUP is highly prevalent and increasing in the ESA region. Key drivers of EUP are poverty, lack of access to SRHR, including contraception, and cultural norms that support child marriage. Very high rates of EUP are documented in rural areas, likely related to child marriage and poverty. The situational analysis found that throughout the region, pregnant girls are stigmatized, blamed and shunned without due consideration for the context or structural factors that increase their vulnerability to an unintended pregnancy.

EUP has a severely negative impact on girls’ education, with the majority of pregnant teenagers and teenage mothers never completing school, hence never breaking the intergenerational cycle of poverty, let alone reaching their potential. It is therefore crucial that investments in preventing and responding to EUP in the region are intensified and that effective strategies are adopted. This needs to include a shift from national policy to localizing policies at school level, with enough advocacy to ensure understanding and acceptance without stigmatizing girls who fall pregnant. Principals, teachers and other school personnel are key, as are parents and other community members.

The following recommendations are offered at regional, national and local levels.

Regional level

• Intensify advocacy to promote regional agreements such as the ESA Commitment by sensitizing ESA countries to the increasing magnitude of the problem and the impact on girls’ education, as well as the implications for economic and social development in the region.
• Develop a regional social and behaviour change communication (SBCC) campaign in collaboration with regional stakeholders and partners to address common and cross-cutting themes related to EUP. Use multi-media, including TV, radio and social media for regional and national campaigns. Youth involvement in campaign development is important.
• Continue to support SRHR/CSE capacity-building for teachers, parents and health care workers. Ensure that Life Skills/CSE curricula include strong pregnancy prevention components prior to puberty, and hence start in primary school. A formal assessment of the reach and impact of the UNESCO CSE training would be useful to determine achievements of this intervention, and identify geographic and programme areas that will require consolidation as the training continues.

National level

• Strengthen and adequately resource multisectoral committees/technical working groups that deal with EUPs to tap into the expertise and roles of different sectors that complement each other, such as education, health, police, social welfare, youth and gender.
• Develop and finalize learner pregnancy management policies depending on country. Policies need to be comprehensive by including the rights and responsibilities of different role players, as well as implementation guidelines and mechanisms to manage learner pregnancy.
• Develop policy for compulsory examinable CSE for all senior school learners that includes substantial hours allocated to high quality, age-appropriate sexuality and relationship education. Strengthen Life Skills curricula to include pregnancy prevention elements from primary school.
• Develop and/or strengthen existing national EUP campaigns with CSO/NGO and government partners. Campaign materials need to be developed and pre-tested within country contexts.
• Disseminate and train education authorities at different levels in learner management and CSE policies.
• Address relevant policies and legislation that may promote EUP; for example, advocacy to review national legislation that has age of consent to marriage under 18 years, and introduction of policies/legislation that allow youth to access contraception. Strengthen poverty alleviation policies and strategies that target young girls and teenage mothers, such as funding/finance programmes.
• Strengthen monitoring and evaluation (M&E) frameworks to track pregnant learners to promote re-entry and support, and monitor implementation of learner pregnancy policies.

Communities

• Sensitize communities on learner pregnancy management policies and related policies/laws so that parents are aware that their daughters can re-enter school after delivering the baby, and what support that can be expected at school level.
• Address perception among school staff and learners that pregnant girls are a bad influence on other youth and the school environment. Involve teenage mothers in school-based EUP prevention and support initiatives. Implement school-level training and sensitization of teachers and principals on de-stigmatization and re-entry policies, as well as structured training of teachers on content and delivery of CSE.
• Implement clinic-level training of health care workers on youth-friendly health services (YFHS) and non-judgemental attitudes. To promote utilization of YFHS, ensure appropriate opening times for learners.
• Strengthen referral systems, especially for youth referrals to clinics from schools. This could include mapping closest clinics and regular meetings with schools and clinic staff, while protecting the privacy of the adolescents who seek services.
• Design and support SBCC programmes that build agency and self-efficacy among young girls to empower them to make healthy decisions about their sexual health. Consider peer support and girls’ SRH clubs to support youth SRHR. Sustainability of such programmes will need to be considered.
• Address cultural practices, especially in rural areas, that promote early marriages and early sexual debut through advocacy campaigns and engaging religious and cultural leaders/gatekeepers.
• Strengthen parent-teacher associations (PTAs) or similar initiatives to promote positive parenting and to complement home- and school-based initiatives on learner pregnancy prevention and management.

Regional EUP campaign

A regional EUP campaign that adopts SBCC approaches has much potential to address issues common to ESA countries. Such a campaign would be strengthened by national campaigns that carry the same and additional context-relevant messages. Based on the findings of the situational analysis, some of the key areas that could successfully be addressed by a regional EUP campaign are:

EUP prevention

• Shifting attitudes of parents, teachers and communities towards adolescent SRHR (ASRHR);
• Strengthening parent-child communication about sexual health, and shifting parents attitudes around contraception;
• Increasing knowledge about and use of contraception, including condoms;
• Building agency and self-efficacy among girls to make healthy decisions about sex and relationships;
• Shifting cultural norms that promote EUP, such as child marriage.

EUP management

• Decreasing stigma and victimization of pregnant teenagers, particularly at community, household, clinic and school levels;
• Creating enabling and safe environments, especially schools, clinics and communities for young girls, both to prevent and support pregnancy;
• Raising awareness of the importance of school completion, especially for girls.
The following table summarizes recommendations for countries to strengthen their responses to EUP using a campaign approach.

<table>
<thead>
<tr>
<th>Country</th>
<th>Policy and advocacy considerations</th>
<th>Target audience considerations</th>
<th>Key issues regarding drivers and consequences</th>
<th>Proposed responses and campaign approaches</th>
</tr>
</thead>
</table>
| All countries | - Develop implementation strategy for re-entry policy, including to raise awareness among public, school personnel and youth about the policies and provisions  
- Promote policies that enable YFHS to be open after school hours  
- Strengthen EUP prevention content in CSE curricular from primary school |                                                                                                    | - High levels of EUP  
- Low levels of contraception use among sexually active girls  
- Transactional sex, fuelled by poverty and peer pressure  
- Lack of skills among parents to communicate SRH issues with children. Parents may hold negative attitudes to adolescent sexuality/contraception  
- Low utilization of YFHS by youth  
- Stigma and discrimination towards pregnant girls. Unsafe abortions sometimes a response exacerbated by stigma  
- Full burden of pregnancy on girl  
- High levels of school dropout for teenage mothers, often due to stigma, and/or financial constraints | - Partner with CSOs and youth when developing EUP programmes, complement existing programmes.  
- Use innovative methods for young people  
- Options to consider: media: radio (especially in rural areas) and listener clubs; public service announcements (PSAs) on radio/TV; social media (target youth)  
- Social mobilization: trainings; young girls’ clubs; teenage mother support groups; community dialogues; parenting workshops; trainings in referral tools and procedures; demand creation activities for YFHS; ensuring schools and YFHS are supportive environments for adolescent girls, pregnant learners and teen mothers  
- Messaging that builds agency and decision-making of adolescent girls  
- Awareness-raising of the magnitude of the problem and what policies are in place at community and school levels  
- Ensure strong monitoring framework  
- Ongoing Life Skills teacher capacity development  
- Ongoing strengthening of referral and linkages between schools and YFS |
| Kenya         | - Finalize draft national re-entry guidelines in Basic Education (2017)  
- Develop policy and legislation for adolescents to consent to access to contraception | - Consider targeting high prevalence regions | - Child marriage, sometimes associated with female genital mutilation, increases EUP in some areas  
- Sexual abuse and coercion contribute to EUP | - Improve coordination of existing EUP prevention efforts and strengthen links between Ministries of Health and Education  
- Target in- and out-of-school girls and enhance male involvement  
- Integrate economic empowerment programmes and social protection mechanisms |
<table>
<thead>
<tr>
<th>Country</th>
<th>Recommended Actions</th>
<th>Challenges</th>
<th>Additional Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho</td>
<td>- Develop re-entry policies</td>
<td>• Consider targeting rural communities where EUP rates are high</td>
<td>• Peer education programmes</td>
</tr>
<tr>
<td></td>
<td>- Develop policy and legislation for adolescents to consent to access to contraception</td>
<td>• Female learners who rent accommodation on their own near school are vulnerable to unprotected sex</td>
<td>• Youth programmes at health care facilities</td>
</tr>
<tr>
<td></td>
<td>- Consider making Life Skills-based CSE an examinable subject</td>
<td></td>
<td>• Address taboo associated with parents talking to their children about sexuality issues</td>
</tr>
<tr>
<td></td>
<td>- Develop policy and legislation for adolescents to consent to access to contraception</td>
<td></td>
<td>• Safe residences/boarding school for learners</td>
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<tr>
<td></td>
<td>- Increase the age that girls can consent to marriage to 18 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td>- Finalize revised Re-admission Policy in draft form (2017)</td>
<td>• Consider targeting rural communities where EUP rates are high</td>
<td>• At community level, work with existing structures such as the youth community-based distribution agents for greater condom coverage for adolescents</td>
</tr>
<tr>
<td></td>
<td>- Develop implementation strategies for access to SRH for young people</td>
<td>• Low levels of knowledge of SRH issues</td>
<td>• Involve faith-based organizations (FBOs) in EUP-prevention initiatives</td>
</tr>
<tr>
<td></td>
<td>- Consider making Life Skills-based CSE an examinable subject</td>
<td>• Sexual violence</td>
<td>• Promote positive parenting</td>
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<tr>
<td></td>
<td>- Develop policy and legislation for adolescents to consent to access to contraception</td>
<td></td>
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<tr>
<td>Namibia</td>
<td>- Strengthen implementation of Education Sector Policy for the Prevention and Management of Learner Pregnancy (2009)</td>
<td>• Consider targeting high prevalence regions</td>
<td>• Build on existing/planned EUP campaigns</td>
</tr>
<tr>
<td></td>
<td>- Consider making Life Skills-based CSE an examinable subject</td>
<td>• Low levels of knowledge of SRH issues</td>
<td>• Strengthen coordination and collaboration for EUP-prevention initiatives</td>
</tr>
<tr>
<td></td>
<td>- Develop policy and legislation for adolescents to consent to access to contraception</td>
<td>• Sexual violence</td>
<td>• Consider messaging related to alcohol and peer pressure</td>
</tr>
<tr>
<td></td>
<td>- Increase the age that girls can consent to marriage to 18 years</td>
<td>• Sexual harassment by teachers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Develop implementation strategies for access to SRH for young people</td>
<td>• Alcohol misuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Consider targeting high prevalence regions</td>
<td>• Sexual violence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Consider targeting high prevalence regions</td>
<td>• Relatively low rates of legal abortions</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>- Finalize draft National Policy on Prevention and Management of Learner Pregnancy (2016)</td>
<td>• Alcohol misuse</td>
<td>• Strengthen coordination across government departments and NGOs and promote synergies with existing initiatives</td>
</tr>
<tr>
<td></td>
<td>- Raise awareness among public, school personnel and youth about policies and provisions</td>
<td>• Sexual coercion and sexual violence</td>
<td>• Link to programmes that address sexual violence and coercion</td>
</tr>
<tr>
<td></td>
<td>- Develop implementation strategies for access to SRH for young people</td>
<td>• Relatively low rates of legal abortions</td>
<td>• Address youth alcohol misuse</td>
</tr>
<tr>
<td></td>
<td>- Consider targeting high prevalence regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>- Develop re-entry policies with implementation guidelines</td>
<td>• Drugs and alcohol promote risky sexual behaviour and children from sexual abuse</td>
<td>• Strengthen existing EUP programmes and collaboration</td>
</tr>
<tr>
<td></td>
<td>- Develop policy and legislation for adolescents to consent to access to contraception</td>
<td>• Parents not sufficiently involved</td>
<td>• Design reintegration programmes for teen parents, including psychosocial support</td>
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<tr>
<td></td>
<td>- Consider targeting community gatekeepers, such as traditional leaders, especially to protect children from sexual abuse</td>
<td></td>
<td>• Develop and test a model for referral between schools and clinics</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Consider messaging related to alcohol and drugs</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>• Strengthen male involvement</td>
</tr>
</tbody>
</table>
**Tanzania**

- Advocacy for right to education of adolescent girls regardless of reproductive health/pregnancy status
- Develop policy and legislation for adolescents to consent to access to contraception
- Increase the age that girls can consent to marriage to 18 years
- Consider focusing on rural areas where EUP rates are high
- Harmful cultural practices, including child marriage in some areas
- EUP not well documented
- Lack of awareness by youth about SRH services
- Strengthen referral to health services through use of community health workers and peer educators; shift condom distribution strategies to communities
- Involve community gatekeepers, such as traditional and religious leaders, in SRH issues
- Address stigma at community level
- Address sexual abuse by educators of learners
- Adopt peer education approaches
- Strengthen livelihood programmes to empower girls
- Shift harmful cultural beliefs and practices

**Uganda**

- Consider focusing on rural areas where EUP rates are high
- Child marriage and harmful cultural practices in some areas
- Teenage mothers are subjected to shame and called different names e.g ogere (second hand) and chibafu (used by many men)
- Teenage mothers tend to lack confidence and have lower self-esteem
- Early marriage and transactional sex are ways that teenage mothers support themselves and their child, if they do not receive parental support
- Parental support key to better outcomes for pregnant teenagers
- Consider projects such as the Teenage Mothers Project which has had success in Eastern Uganda
- School clubs encourage child participation
- Advocacy and social change programmes/campaigns need to address attitudes and norms at all levels
- Promote gender equality content in schools
- Target traditional leaders to shift cultural practices that promote EUP

**Zambia**

- Raise awareness among the public, especially parents, about the re-entry policies and provisions
- Develop policy and legislation for adolescents to consent to access to contraception
- Consider focusing on rural areas and geographical regions where EUP rates are high
- Child marriage in some areas
- Early pregnancy considered shameful, especially for the parents
- In some rural communities, childbearing adolescents are accepted since they bring in family income via bride price
- Peer education programmes
- Outdoor media and PSAs
- Health care worker (HCW) attitudes
- FBOs are important
- Advocacy and social change programmes/campaigns need to address attitudes and norms at all levels
- Strengthen collaboration and partnerships across government departments
- Strengthen re-entry monitoring framework
- Use talk shows, drama and theatre for SSCC
- Use youth role models and champions
- Leverage information and communication technology (ICT) to promote youth-friendly approaches for campaigns and messages

**Zimbabwe**

- Develop specific re-entry policies. Raise awareness on contents of circular
- Develop policy/legislation for adolescents to consent to access to contraception
- Strengthen implementation of the Zimbabwe Family Planning guidelines
- Consider focusing on rural areas where EUP rates are high, as well as regions such as Maslonaland Central, border areas, mining communities and border posts
- Pregnant teenagers are considered a bad influence, perceived as promiscuous and deviant. They tend to have low self-esteem and fear being ridiculed by learners and teachers
- Strengthen referral to health services through use of community health workers and peer educators; shift condom distribution strategies to communities
- Involve community gatekeepers, such as traditional and religious leaders, in SRH issues
- Address stigma at community level
- Address sexual abuse by educators of learners
- Adopt peer education approaches
- Strengthen livelihood programmes to empower girls
- Shift harmful cultural beliefs and practices
Situational analysis on early and unintended pregnancy in Eastern and Southern Africa
Section 01

Introduction and methodological approach
Introduction and methodological approach

Motivation and rationale

UNESCO and partners will launch a regional campaign to address early and unintended pregnancies (EUPs) to promote the educational, social, and health status among girls and young women in the region. This document reports on a situational analysis that was conducted by Research and Training for Health and Development (RTHD) consultants from September to December 2017 to inform campaign development.

EUP is a global public health concern in both developed and developing countries that has a significant impact on the lives of adolescent girls. Worldwide, sub-Saharan Africa carries the highest burden of adolescent pregnancies both outside and within marriage, many of which are unintended (WHO, 2012; UNFPA 2013). Among other negative consequences for adolescent girls, including for their health, social, and economic outcomes, EUP jeopardizes educational attainment due to school drop-out and decreased school completion. Preventing EUP is therefore an important component of a wider response to ensuring the right to education for all girls, requiring an effective response from the education sector in collaboration with other sectors. Currently, however, the status of the education sectors’ response to EUP varies from country to country across the Eastern and Southern African (ESA) region, and a lack of access to sexual and reproductive health and rights (SRHR) for young people has been recognized as a key driver of EUP. Limited access to information and services to enable adolescents to make informed choices about issues such as sexual debut and contraception also contributes to EUP, with an estimated 2.4 million 15-19-year-olds reported to have an unmet need for contraception in the region (UNESCO, 2016). Child marriage is another driver of EUP, with more than a third of women aged 20-24 having been married or in a union before the age of 18 (UNESCO, 2017).

In 2013, the Eastern and Southern African Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People (henceforth the ESA Commitment) was signed by ministers of health and education from 21 countries in the region. It aims to scale up comprehensive sexuality education (CSE) and sexual and reproductive health (SRH) services for adolescents and young people in ESA, given the low school completion rates and high levels of HIV incidence, EUPs, child marriages, and poverty and inequality. The ministers committed to a set of actions that would substantially promote SRHR in the region, including reviewing/amending existing laws and policies on age of consent, child protection and teacher codes of conduct, keeping young people in school, and initiating and scaling up age-appropriate CSE during primary school education. Targets by 2020 include reducing EUP by 75%, training 90% of teachers in CSE, and integrating CSE curricula in 90% of schools (UNESCO, 2014). After two years of implementation, 15 out of the 21 countries reported providing CSE in at least 40% of primary and secondary schools (UNESCO, 2016).

The UNESCO EUP campaign is a key strategy that contributes to achieving the ESA Commitment’s goals and targets. Moreover, addressing EUP is a crucial development intervention that will directly contribute to the Sustainable Development Goals (SDGs) of 2016, in particular Goal 3: Good Health and Well-being; Goal 4: Quality Education; and Goal 5: Gender Equality. The campaign will seek to reduce EUP through increasing awareness of its consequences, improving CSE delivery, promoting consistent condom use, and increasing access to and use of effective contraception for sexually active young people.

The objectives of the situational analysis were to:

- Present the latest data on the magnitude of EUP and the impact on girls' education in the ESA region;
- Provide an analysis of policy and programme responses to EUP in 10 ESA countries;
- Review relevant legislation in the selected countries, based on a recent United Nations Population Fund (UNFPA) study;
- Develop specific recommendations for improving country responses to EUP.

Methods

The situational analysis included Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Uganda, Tanzania, Zambia and Zimbabwe. The countries were selected to ensure a distribution of countries from both Eastern and Southern Africa were included. In addition, language (English) and logistical considerations, such as familiarity with local contexts, were considered.

The situational analysis consisted of three components:

Desk review

The desk review was guided by the UNESCO framework, Developing an Education Sector Response to Early and Unintended Pregnancy: Discussion Document for a Global Consultation, 2014 (Birungi et al., 2014). It reviewed relevant legislation, policies and programmes, as well as recent literature and online quantitative datasets in all 10 countries, and focused on:

- EUP management policies, specifically school re-entry, continuation, and/or expulsion of girl learners who are pregnant;
- EUP prevention policies, specifically on CSE;
- Linkages between the education and health sectors to facilitate access/referrals to youth-friendly health services (YFHS) and eliminate stigma.
The most recent Demographic and Health Surveys (DHS) were used for the quantitative data review in all countries except Swaziland, where the DHS was outdated and the United Nations Children’s Fund (UNICEF) Multiple Indicator Cluster Survey (MICS) dataset was used instead. The DHS childbearing indicator “Percentage of women aged 15-19 years who have given birth or are pregnant with their first child” was analysed by rural/urban residence, education level, socio-economic status, and pregnancy intention. For Swaziland, the MICS indicator “Percentage of women aged 20-24 years who have at least one live birth before the age of 18 years” was reviewed. Additional key adolescent SRH (ASRH) indicators were reviewed for each country, namely, sexual activity by 18 years and modern contraception use among 15-19-year-olds (overall, for those married, and for those unmarried but sexually active).

The literature review used Medline and Popline databases, and included published articles and unpublished reports from the 10 countries, focusing on the last five years. Database searches included the key words: early and unintended pregnancy, teenage pregnancy, adolescent pregnancy, Eastern and Southern Africa. The literature search revealed very little to no recent published research from Swaziland and Lesotho.

The policy and legislation desk review included the following documents:

3. National education policies that address EUP in the 10 countries, where available.
4. National youth and reproductive health policies in the 10 countries.

Qualitative field work

The field work was conducted in four of the countries (Malawi, Uganda, Lesotho and South Africa) consisting of key informant interviews (KIls) and focus group discussions (FGDs) using semi-structured interview guides (see Appendix 1). The main aim of the KIs and FGDs was to gain rich narratives and case studies of the situation on the ground from the perspectives of young women, community members, and parents, as well as key informants that could inform campaign messaging. The fieldwork started mid-November 2017 in Malawi. This field work also served as a pre-testing exercise to assess whether the questions in the tools were appropriate, relevant and understandable.

Between four and six KIs were conducted in each of the four countries, depending on availability of respondents, logistics and budget. The key informants were drawn from:

- Officials from the Ministries of Education, Health, Youth, Gender, or from ministries closely involved in EUP in a specific country;
- Representatives of civil society/non-governmental organizations (NGOs) working on EUP in the region;
- Community-based stakeholders including school principals, Life Skills teachers, and/or health workers responsible for reproductive health services.

Four FGDs were conducted in each country (two in urban and two in rural areas), where groups were segmented into young mothers, out-of-school girls over the age of 18, and parents/adult community members. Except for in Uganda, where translators were recruited, the FGDs were conducted in the language of the respondents. With permission from participants, the discussions were audio-recorded, and then transcribed verbatim and analysed thematically.

A breakdown of the interviews conducted is provided in Table 1. For some KIs, two or three respondents were interviewed at the same time e.g. Malawi school representatives and Uganda Civil society organization (CSO) representatives, hence the number of key informant respondents was 24 in total.

National stakeholder dialogues

With support from the UNESCO regional office and UNESCO national programme officers (NPOs), national dialogues among stakeholders on EUP were organized and documented in the remaining six countries (Kenya, Namibia, Swaziland, Tanzania, Zambia and Zimbabwe). The dialogues followed the same objectives, agenda, and format across countries based on an open-ended dialogue tool. The objectives were to: (i) understand the national policy and programmatic response to EUP in the country; (ii) understand the education sector response to EUP (including provision of quality CSE and implementation of re-entry policies); (iii) understand linkages (referral system) between schools and health services in enhancing adolescent access to the health and education services; and (iv) understand the forms and impact of stigma and discrimination on pregnant and childbearing girls in schools and communities (see Appendix 2).
Dialogues were held as half-day workshops where the following representatives, among other stakeholders, participated:

- Government officials from Ministries of Health, Education, Social Welfare, Gender, Youth, and Justice
- CSOs working on EUP in the region
- Youth representatives
- Community health and social workers
- Teachers
- Parents

The dialogues were carefully documented so that the reports could be used as primary data for the regional analysis and integrated into country level summaries.

Data from the desk review, quantitative and qualitative analyses, and dialogues were triangulated to verify findings and assess the consistency of the data.

**Limitations and challenges**

- A key challenge was the limited time available to conduct the situational analysis given the scope. Nevertheless, RTHD assembled a team of consultants who implemented the research elements, including field work in four countries, and this was very well supported by UNESCO NPOs. The national dialogues were organized and managed by the UNESCO NPOs and the UNESCO regional office supported the process. This collaborative effort proved successful in ensuring that the situational analysis could be implemented within the time constraints.

- Parent groups were predominantly made up of women. It was difficult to find willing men to attend the groups, hence the perceptions of this important segment was not fully captured. The Lesotho parent group did, however, have some men in attendance.

- It was difficult to find out-of-school youth who did not have children. The out-of-school groups were therefore a mixture of young mothers and girls who did not have children.

- The fieldwork was conducted during school exam period. As a result, it was difficult to recruit some key informants or participants from the education sector. In South Africa, the process of gaining approval to interview school-based staff from the Department of Basic Education (DBE) is very lengthy and given the time of year, it was not possible to secure interviews. However, RTHD did manage to interview a Life Orientation teacher after hours.

- In Malawi, South Africa and Lesotho, all FGDs were conducted in the local languages, but in Uganda, community level interviews were done through an interpreter. Although this disturbed the flow of the discussion, RTHD hired a local transcriber who translated and transcribed the interviews verbatim to maintain the richness of the data.

- Through the field work process, it emerged that individual in-depth stories/case studies from young mothers about EUP would enrich the data. Should resources permit, additional in-depth interviews from this key group would be desirable.

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**Table 1: Breakdown of KIIs and FGDs in four ESA countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Key informant interviews</th>
<th>Focus group discussions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Govt. rep</td>
<td>Govt. rep</td>
</tr>
<tr>
<td>Lesotho</td>
<td>MoET rep</td>
<td>Adolescent health manager (MoH)</td>
</tr>
<tr>
<td>Malawi</td>
<td>Head of policy and planning, MoEST</td>
<td>National coordinator AYSRH, MoH</td>
</tr>
<tr>
<td>South Africa</td>
<td>Head of HIV, TB and learner pregnancies, DBE</td>
<td>Research manager, National Population Unit, DSD</td>
</tr>
<tr>
<td>Uganda</td>
<td>Gender technical advisor, MoE</td>
<td>Principal probation officer – Children Affairs Division, Min of Gender</td>
</tr>
</tbody>
</table>
Section 02
Regional findings
Situational analysis on early and unintended pregnancy in Eastern and Southern Africa
Regional findings

In this section, cross-cutting regional findings are presented. Country level findings for each of the 10 countries are presented as national summaries in section 4.

Magnitude of EUP

The ESA region has among the highest adolescent fertility rates in the world. As indicated in Table 2, the percentage of 15-19-year-olds who are mothers or pregnant and the proportions of EUPs in the 10 ESA countries are high. In all countries, at least 15% of young women aged 15-19 years have started reproduction, while in Malawi, Tanzania, Uganda and Zambia, at least a quarter have experienced pregnancy or early childbearing. At least a third of early pregnancies are unintended in this age group in all countries, reaching 70% in Namibia.

Respondents at all levels (national, school and community) acknowledged the high prevalence of EUPs in their communities. Furthermore, EUPs were reported to be on the increase, with girls getting pregnant as young as 14 years. For instance, in Malawi, pregnancy rates have increased from 26% in 2010 to 29% in 2016 according to the DHS. In Zambia, there were over 15,000 teenage pregnancies recorded in 2016, up from less than 14,000 in 2014. Similarly, in Zimbabwe, adolescent fertility rates increased from 99/1,000 in 2006 to 120/1,000 in 2014 (UNFPA, 2016). As the sections that follow will demonstrate, EUP disproportionately affects girls.

“... when a boy impregnates a girl, he is not much bothered by it and neither are his family members. He can finish school unlike the girl where she struggles at home and at school.” – Tanzania National Dialogue, 18 December 2017

School-based key informants reported increasing cases of girls getting pregnant and subsequently dropping out of school, as well as cases of ‘backstreet’ abortions, including in contexts where abortion is illegal. Key informants noted that the numbers of EUPs and school dropouts are underreported because some girls who get pregnant drop out of school without reporting their status.

“We are passing on the message but the situation is not changing. For example we had nine girls pregnant in 2014/15 academic year, in 2015/16 we had seven pregnant; and many stories of backstreet abortions.” – High school deputy head and Life Skills teacher, urban Malawi, November 2017

“... this year alone half the Grade 12 class in my school were pregnant... some did not write exams.” – Life Orientation teacher, urban South Africa, November 2017

Table 2: Percentage early childbearing and unintended pregnancies in 10 ESA countries based on DHS and MICS data

<table>
<thead>
<tr>
<th>Country</th>
<th>Early Childbearing (15-19 years who have given birth or are pregnant with first child)</th>
<th>Unintended Pregnancy (15-19 years that are unintended)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya2014</td>
<td>18.1</td>
<td>47.3</td>
</tr>
<tr>
<td>Lesotho2014</td>
<td>19.1</td>
<td>56.0</td>
</tr>
<tr>
<td>Malawi2015/2016</td>
<td>29.0</td>
<td>41.1</td>
</tr>
<tr>
<td>Namibia2013</td>
<td>18.6</td>
<td>69.8</td>
</tr>
<tr>
<td>South Africa2016(*)</td>
<td>15.6</td>
<td>-</td>
</tr>
<tr>
<td>Swaziland (MICS)2014</td>
<td>17.4</td>
<td>-</td>
</tr>
<tr>
<td>Tanzania2015</td>
<td>26.7</td>
<td>32.6</td>
</tr>
<tr>
<td>Uganda2014(*)</td>
<td>24.8</td>
<td>-</td>
</tr>
<tr>
<td>Zambia2013/2014</td>
<td>28.5</td>
<td>46.1</td>
</tr>
<tr>
<td>Zimbabwe2015</td>
<td>21.6</td>
<td>37.6</td>
</tr>
</tbody>
</table>

* Full DHS report not available: based on summary of key indicators report.
Drivers and determinants of EUP

In this section, the drivers and determinants of EUP are presented by socio-economic factors, cultural and gender norms, service availability, and individual/interpersonal factors, noting that these are often interrelated.

Socio-economic and demographic drivers

The most recent data on early childbearing for the 10 countries by residence, education, and income is found in Table 3.

Table 3: Percentage of young women aged 15-19 years who have given birth or are pregnant with their first child by residence, education, and wealth in 10 countries based on DHS and MICS data.

<table>
<thead>
<tr>
<th>Country</th>
<th>Residence</th>
<th>Education</th>
<th>Wealth quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Overall</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Kenya</td>
<td>18.1</td>
<td>17.3</td>
<td>18.5</td>
</tr>
<tr>
<td>Lesotho</td>
<td>19.1</td>
<td>11.7</td>
<td>22.5</td>
</tr>
<tr>
<td>Malawi</td>
<td>29.0</td>
<td>21.3</td>
<td>30.7</td>
</tr>
<tr>
<td>Namibia</td>
<td>18.6</td>
<td>16.7</td>
<td>20.3</td>
</tr>
<tr>
<td>South Africa</td>
<td>15.6</td>
<td>13.6</td>
<td>18.6</td>
</tr>
<tr>
<td>Swaziland (MICS)</td>
<td>17.4</td>
<td>18.5</td>
<td>17.0</td>
</tr>
<tr>
<td>Tanzania</td>
<td>26.7</td>
<td>18.5</td>
<td>31.6</td>
</tr>
<tr>
<td>Uganda</td>
<td>24.8</td>
<td>18.8</td>
<td>26.7</td>
</tr>
<tr>
<td>Zambia</td>
<td>28.5</td>
<td>20.0</td>
<td>36.4</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>21.6</td>
<td>10.3</td>
<td>27.2</td>
</tr>
</tbody>
</table>

*Fewer than 25 cases or no cases, **primary incomplete/primary complete, ***secondary incomplete/secondary complete.

Rural versus urban residence

In most countries, pregnancy rates were higher in rural than urban areas, with particularly large differentials (>10%) in Tanzania, Zimbabwe, Lesotho and Zambia. Minimal urban rural differences were noted in Kenya and Swaziland. In five of the countries (Malawi, Tanzania, Uganda, Zambia and Zimbabwe), 25% of rural girls were pregnant or mothers by the age of 18.

Educational status

In most countries, lower educational levels were associated with higher rates of teenage pregnancy. More than 50% of girls with no education had experienced a pregnancy in Tanzania, Malawi and Zambia.

Poverty

Higher socio-economic status was protective in all countries (see Table 3). Socio-economic factors are key in driving child marriage and/or teenage pregnancy, because the poorest families are unable to afford education and there are few options for girls to develop the skills needed to generate income to move themselves and their families out of poverty. Transactional sexual relationships are common and related to both poverty/survival and to the need to obtain material goods that are otherwise unaffordable. These relationships place girls at high risk for unprotected sex, and hence pregnancy, due to their inherent power imbalance.

It was reported that girls have early sexual debut with men, from whom they expect gifts, due to poverty and this has also led to the increase in intergenerational sexual relationships as most men who can provide for the girls' needs are older. In some instances, parents are also said to force their daughters into marriage to relieve themselves of the burden of taking care of them and benefit from marriage gifts including bride price.

“We had a case of a girl who fell pregnant twice and when we talked to parents they said the man who made the girl pregnant helps the girl and the family.” – Deputy Head and Life Skills teacher, urban Malawi, 13 November 2017

“We had a case of a girl who fell pregnant twice and when we talked to parents they said the man who made the girl pregnant helps the girl and the family.” – Deputy Head and Life Skills teacher, urban Malawi, 13 November 2017

“Some girls leave school because of various problems they encounter at home. Some lack soap, exercise books, etc. because their parents do not have money. As a result they drop out of school to get married hoping to find peace at their own home and hoping that the husband will be buying things like soap. And in search of these things some girls are impregnated because they go out there looking for men who can assist them with basic needs.” – Rural out-of-school female youth FGD, Malawi, November 2017

The impact of many policy and programmatic responses to EUP is also undermined by the exigencies of poverty. For instance, following the increase in marriage age to 18 years in Malawi, many organizations embarked on a campaign to take young girls out of marriage and take them back to school. However, stakeholders bemoaned the fact that this is not working as many girls are returning to their marriages because that is where they get economic support.
sexual debut and EUP: to get married. Similarly in Malawi, cultural practices promote early marriage, especially in rural areas. In Karamoja in Uganda, for instance, after FGM girls as young as 15 years are supposed to get married. Similarly in Malawi, cultural practices promote early marriage and EUP.

Cultural and gender norms

Socio-cultural practices compound economic factors since these determine gender norms that dictate girls’ and women’s roles in society, including decisions about the appropriate time for sexual activity, marriage, desired family size, and the use of family planning.

Child marriage

Early marriage and early sexual debut are strongly associated with EUP. While early marriage is not as prominent in the South African context, some two-thirds of adolescent mothers in East Africa and 32% in Southern Africa are already married by the age of 16 (UNESCO, 2014). As already highlighted in the section on poverty above, some parents force their daughters to enter early marriage because of the financial implications of their unmarried daughters falling pregnant. Some girls choose to get married early to get financial support from their husbands.

“Sometimes the child can have a mind of continuing with school, but the parent forces the child to enter into marriage because of poverty... Another problem is lack of understanding on the part of the parents of the benefits of educating girls. Most parents just think that when a girl reaches puberty they should be relieved of her and send her to marry so that they should also get something out of it” – Rural parents’ FGD, Malawi, November 2017

“Others love money, they can say, this guy has money. I can give an example from the village, I grew up here with my aunt and when I reached in village, in senior three I think, then the neighbours started saying ‘Aaaah, William has got money’, this is cattle, so whenever I go there they ask ‘When are you getting married? We want things, we want cows...’ They demand, even parents themselves they demand we want cattle, we want cattle, eeee that one is also a challenge” – Urban out-of-school girls’ FGD, Uganda, December 2017

“Even the parents themselves can force you to get married especially when you get pregnant when at school, they can tell you this money (for your school) is now finished, you can stop at that level, go get married. So through that process, you get married, you don’t know anything, you reach there, the family of the boy is very poor...” – Urban out-of-school girls’ FGD, Uganda, December 2017

Gender-based violence and child abuse

Cases of child abuse and rape have also contributed to EUPs in communities in the region. This was especially associated with older men abusing young girls either in a relationship or guardians such as uncles sexually abusing girls at home. Walking long distances to school and other amenities also exposed young girls to sexual abuse and rape. Alcohol and drug abuse were reported to contribute to rape and abuse as well. In some cases, men were reported to use drugs to spike girls’ drinks and sexually abuse them.

“Girls starting from the age of 10 are looked at by men as grown women and that’s so painful because they’d call her and buy her sweets and the child knows nothing, absolutely nothing about their intentions and the next thing they take her and do something... Like the guy would be giving this kid R5 now and then and then the child is impressed... Plus today’s children are just too... they grow up too quickly... And when the guy asks to kiss her she’ll remember that she had heard about kissing from a friend and then she kisses him, next thing the guy will ask the girl to prove her love and they get onto the bed and they sleep (have sex)... Even though it’s not rape and she consented and then she falls pregnant or something while she’s still 12 or 13 years of age...” – Rural out-of-school girls’ FGD, South Africa, December 2017

“... they (NGOs) take girls from marriages and just dump them at home without any support. Due to poverty, the girls end up going back to their marriages.” – Head of Policy and Planning Unit, MoEST, Malawi, November 2017

“Girls starting from the age of 10 are looked at by men as grown women and that’s so painful because they’d call her and buy her sweets and the child knows nothing, absolutely nothing about their intentions and the next thing they take her and do something... Like the guy would be giving this kid R5 now and then and then the child is impressed... Plus today’s children are just too... they grow up too quickly... And when the guy asks to kiss her she’ll remember that she had heard about kissing from a friend and then she kisses him, next thing the guy will ask the girl to prove her love and they get onto the bed and they sleep (have sex)... Even though it’s not rape and she consented and then she falls pregnant or something while she’s still 12 or 13 years of age...” – Rural out-of-school girls’ FGD, South Africa, December 2017

“The time when we have gone out to entertain ourselves, that’s when men give us drugs to use us any way they want either sexually or otherwise. They spike our drinks” – Young mothers’ FGD, Lesotho, December 2017.

Cultural practices

Cultural practices such as initiation ceremonies and female genital mutilation (FGM), are also said to encourage young girls to have early sexual debut and early marriages. This was prominently reported in Uganda, Kenya and Malawi, especially in rural areas. In Karamoja in Uganda, for instance, after FGM girls as young as 15 years are supposed to get married. Similarly in Malawi, cultural practices promote early sexual debut and EUP.

1 Having sex with a minor is, however, legally statutory rape.
Situational analysis on early and unintended pregnancy in Eastern and Southern Africa

Access to SRH services

Table 4 presents sexual activity among adolescent girls in relation to contraception use in the 10 countries. It confirms that there is a wide gap between the percentage of sexually active young women aged 15-19 years and those that use modern contraception. For example, in Malawi, while 64% of young women are sexually active, only 15.2% use modern contraception. In Tanzania and Zambia, only 33% and 18% of unmarried sexually active young women age 15-19 years use modern contraception, respectively.

It would seem that, because of the stigma associated with EUPs as reported in the section on stigma and discrimination (see below), many girls do everything necessary to prevent pregnancy, including using abortion. However, the majority of these contraceptives are accessed through commercial pharmacies other than clinics because most clinics are not youth-friendly.

"... you can just go to the pharmacy to buy those pills, because once you go to the doctor (clinic), the doctor will ask you 'at that age of yours why do you want to join family planning?... So I just go to the pharmacy and buy my pills." – Urban out-of-school girls’ FGD, Uganda, December 2017

Limited use of SRH services

There is limited use of SRH services, such as contraceptives, among sexually active adolescents. This was attributed to general lack of knowledge, as well as unavailability and/or inaccessibility of SRH services for youth. Even where available, the SRH services were inaccessible to many young people as a result of judgmental service providers, long distances, and opening hours only during school time.

"It is shameful going there. The first question one is asked is whether they are married. If not, they are told that they will get infected with HIV and other STIs. They will mock you that you are already having sex before marriage and now you want family planning to have all liberty to have more sex, do you understand?" – Urban out-of-school girls’ FGD, Lesotho, December 2014

"This is because the health workers according to their profession and belief they sometimes ask the girls questions why they want to practice family planning when they are not married, and sometimes citing the bible that it does not condone, so the girls feel embarrassed and as a result they fail to go back there." – Urban out-of-school girls’ FGD, Malawi, December 2014

Table 4: Sexual activity and modern contraception use among adolescents based on DHS

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>SEXUAL ACTIVITY</th>
<th>MODERN CONTRACEPTION USE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% young women aged 20-24 years who had sex by age 18 years</td>
<td>% all young women aged 15-19 years</td>
</tr>
<tr>
<td>Kenya 2014</td>
<td>50.0</td>
<td>9.3</td>
</tr>
<tr>
<td>Lesotho 2014</td>
<td>42.0</td>
<td>19.7</td>
</tr>
<tr>
<td>Malawi 2015/16</td>
<td>64.0</td>
<td>15.2</td>
</tr>
<tr>
<td>Namibia 2013</td>
<td>39.7</td>
<td>24.1</td>
</tr>
<tr>
<td>South Africa 2013(*)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Swaziland (DHS) 2006/2007</td>
<td>46.3</td>
<td>26.9</td>
</tr>
<tr>
<td>Tanzania 2012</td>
<td>47.0</td>
<td>8.6</td>
</tr>
<tr>
<td>Uganda 2016(*)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Zambia 2013/2014</td>
<td>58.0</td>
<td>10.2</td>
</tr>
<tr>
<td>Zimbabwe 2015</td>
<td>40.9</td>
<td>12.1</td>
</tr>
</tbody>
</table>

* Full DHS report not available. Based on summary of key indicators report.

"And with the clinics... Like in the rural areas that I come from, you’ll find a line for sick people and the ones for contraception, they will be passing remarks like 'you are still a child but you want to do adult things' and when they do that you get discouraged and you thinking it’s better you go have sex just like this..." – Rural out-of-school girls’ FGD, South Africa, December 2017

"Like I was saying even at the clinic... the treatment they get is not friendly, it’s too judgmental in front of people. Do you think she will come back next time for her injections? We see these things..." – Parents’ FGD, South Africa, December 2017

There was, as a result, a marked difference between girl respondents who had children and those without, where girls who had children reported using contraceptives more than those who had no children. This was partly due to the fact that girls with children were treated as parents at health services, and had a higher risk perception than girls without children.
Interpersonal and individual factors

Peer pressure

Peer pressure which influenced girls to get into sexual relationships was another driver of EUPs in the region. It was reported that many girls admire their friends’ material things and they end up in sexual relationships if the relationships promise the reward of such materials. Girls therefore often get into sexual relationships with men, especially older men, who can provide for these wants. This was compounded by factors such as alcohol and drug abuse, which increase young people’s risk of engaging in unprotected sex.

“Like Monica can have that phone, clothes or hair and I can admire her and then a guy will come, ‘you know what Harriet, what do you want?’ I want a phone like Monica’s, eee, just a phone, and he will buy for you, and the next day you will go and have sex with him and then you will get pregnant.” – Urban out-of-school girls’ FGD, Uganda, December 2017

“I think that girls from the age of 12 are very vulnerable to older men because since I don’t have pocket money to go to school... A guy comes to me and tells me... he’s going to buy me jeans... they come and look at you ‘your hairstyle...’ and even when I look at my next door neighbour I actually thought this guy is making sense because I will only sleep with him once and I will get the hairstyle and I’ll be just as good as my neighbour.” – Rural out-of-school female youth FGD, South Africa, December 2017

“Mostly it is peer pressure because in most cases we don’t normally date our age groups, we are attracted to guys who are employed only to find that we don’t have a say in that kind of a relationship. An older guy will be spoiling me with gifts and when comes a time whereby he wants us to be intimate, I can’t refuse and say that he is older than me because he will state that he does everything for me and he may even refuse to use a condom saying that his gifts come unwrapped and I can’t expect him to use a condom in return.” – Young mothers’ FGD, Lesotho, December 2017

“Sometimes its peer pressure. When a girl sees that their friend has a boyfriend and they brag about being taken care of, the other girls are also pressured to find boyfriends.” – Rural out-of-school FGD, Malawi, November 2017

Girls also reported that many men refuse to use condoms and they end up having unprotected sex.

“It’s just that sometimes when you ask your partner to use a condom (he thinks) you are cheating... Or what’s the problem, are you afraid you are going to infect me’ and then you just say ‘no, baby it’s fine’... Don’t you trust me?” – Rural out-of-school girls’ FGD, South Africa, December 2017

Parenting

There is evidence to suggest that peer pressure and its effects are compounded by parents not having resources or not being willing to cater for their daughters’ needs or wants, leading them to into sexual relationships that promise to provide these. Furthermore, the nature of the relationship between daughters and parents also appears to be an important element in this dynamic.

“... the problem comes from home if only I agree with mummy and daddy and I tell them what I want and they are in position to give it to me, I won’t admire friends and go to men to get money where one end up getting unwanted pregnancy. But if daddy or mummy tells me they don’t have money I will admire friends, or if mummy is very tough (you) go anywhere... outside home which makes them get unwanted pregnancy. The way parents talk, they scare the child but if the parents talk well at home and have good relationship at home it’s very hard for children to go out and get unwanted pregnancy.” – Young mothers’ FGD, Uganda, December 2017

While there are parents who support the idea of girls using contraceptives to prevent pregnancies, many feel that contraceptives promote promiscuity, can expose girls to sexually transmitted infections (STIs), especially if condoms are not used, and can, in some cases, result in girls failing to conceive in future. This partly explains girls hiding the use of contraceptives from their parents, or not accessing them at all.

“These things (contraceptives) came but they are causing our children to go astray because they are not scared of anything and they do have lasting effects, some of the girls fail to give birth after marriage because of pills. And the increase in promiscuity is bringing in diseases, because some of the ways protect them from pregnancy and not diseases.” – Parents’ FGD, Malawi, November 2017

“I don’t support it (contraceptives). I speak to the girl and advise her to abstain, but I can’t come out and say that I support her to go take contraceptives.” – Parents’ FGD, Uganda, December 2017

“They also say that these contraceptives destroy their bodies.” – Parents’ FGD, Lesotho, December 2017

“Again, because some of the people who work in the clinic are from here, they will start spreading rumours about us. And if it gets to our parents they are not going to be happy at all... For some of us our parents are not even aware that we use a pill, if they found out they would know that we have started having sex and they will be disappointed in us.” – Rural out-of-school girls’ FGD, Lesotho, December 2017

Because in some cultures, such as in Uganda and Malawi, discussing sex between a parent and a child is considered a taboo and therefore, many parents do not talk about it. Even in cases where parents do talk with their daughters about sex and growing up, the girls are reported to be keen on experimenting and parents (and teachers) are said to:

“... lack the ability to communicate sexuality related issues due to cultural influence and lack of correct and accurate knowledge.” – Kenya National Dialogue, 5 December 2017

“... fail to talk to our children about the use of contraceptives and we also don’t make them aware of the consequences of unprotected sex.” – Parents’ FGD, Lesotho, December 2017

“... lack involvement; parents need to be supportive and do their parenting duties. Children should not be left to find their own way around about life and survival.” – Urban Life Orientation teacher, South Africa, November 2017
Positive parenting, where parents are in close touch with their children and communicate SRH issues in an open and constructive manner, is therefore needed. This came against the backdrop of many girls learning about sex and growing up from largely unreliable sources such as peers and social media.

“Parents need to know and be aware of the current situation and be open to providing the SRH education.” – Tanzania National Dialogue, 18 December 2017

‘We don’t learn, we experience’
While girls reported learning about sex and growing up from mass and social media, NGOs, schools and peers, and sometimes from elders and churches, it was clear from the FGDs that most girls learn a lot through experience.

This was compounded by parenting shortfalls in this area, as presented in the section above. As a result, by the time girls grasp ways of preventing EUPs, they will have already experienced sex and some will have already gotten pregnant.

“We don’t learn but we experience... I never learnt about sex and I never even wanted to learn about it. My mom is a very quiet person, and she doesn’t want to speak about such things. So, I learnt about sex by experiencing and that’s how I knew and even learnt about the consequences through me experiencing and nobody told me. Some parents are afraid to talk. They don’t want to talk about sex...” – Rural out-of-school girls’ FGD, South Africa, December 2017

“These are issues that we experience or are experienced by our peers.” – Urban out-of-school girls’ FGD, Lesotho, December 2017

“Sometimes our parents do not disclose these issues to us and we fall pregnant without knowing about them. I think it is necessary for parents to talk to their children about sexual and reproductive health issues.” – Urban out-of-school girls’ FGD, Lesotho, December 2017

“I say once my girl starts menstruating only then I will tell her that it means she has grown into a woman and once a boy penetrates her she will get pregnant and also get exposed to STI out there. I try and explain these to them but they continue experimenting... ‘Amanzomazane afuna ukunambitha amaswidi esiwadlayo’ (the girls want to taste the sweets we eat)” – Parents’ FGD, South Africa, December 2017

Context and consequences of EUP
Key consequences of EUP are poor educational, physical, economic, and emotional outcomes. Moreover, teenage pregnancies are highly stigmatized in communities, schools and, often, at home. Stigma and victimization pervades the experience for many girls, and this exacerbates the negative impacts. Her life prospects can be severely undermined since she is unlikely to complete school and have further education and/or income generation opportunities.

“This child’s one mistake follows her through all her stages of growing up, sometimes destroying her life for good.” – CSO KII Lesotho, December 2017

Health and psychosocial impact on physical and emotional well-being
Adolescent pregnancy places girls at increased risk of unsafe abortions, difficulty during childbirth, pregnancy-related mortality and morbidity, and HIV and other STIs. Studies that have explored longer-term mental health and social consequences of teenage pregnancy show that these include depression, substance abuse, and increased sexual risk behaviour, as well as lower educational attainment and socio-economic status (Christofides et al., 2014). Moreover, if the pregnancy was as a result of rape/coerced sex, she is likely to experience emotional trauma. She may be shunned by her family or community and be unable to receive support from health services. Girls reported going through such emotional pain especially because of denial and societal rejection and ridicule. This is expanded on in the section on stigma and discrimination below.

“They go through pain because most of the times they are rejected by the one who impregnated them, so the girl goes through emotional pain thinking why she did it. Plus during pregnancy, you require so many things which the girls don’t have most of the time. They go through emotional pain because they are ridiculed by their peers.” – Rural out-of-school female youth FGD, Malawi, November 2017

A notable risk of EUP is unsafe abortion. Across all 10 countries it was reported that many girls risk unsafe abortions to avoid the shame, ridicule, dropping out of school, and responsibility associated with raising a child. Unsafe abortion occurs commonly in countries where it is illegal, but even in countries where it is legal, such as South Africa, it still occurs to avoid the expenses associated with medical abortion, and/or to avoid being noticed or shamed.

“Stigma might also lead to unsafe abortion. When one hears those humiliating hurting things about her they resort to abortion. And this is a challenge on its own as we often go to back street abortions and die.” – Urban out-of-school female youth FGD, Lesotho, December 2017

“Sometimes they don’t have anywhere to go because parents have chased them away and the man also refuses to take responsibility therefore some may want to take drugs... With the rejection from parents and the man the girls go through torture and sometimes decide to take drugs to remove the pregnancy. So you find out that some girls are able to marry after abortion” – Rural out-of-school girls’ FGD, Malawi, November 2017

Some are ashamed of living with the pregnancies, so they abort... some fear dropping out of school” – Semi-urban out-of-school girls’ FGD, Uganda, December 2017

“Because of rejection and or associated threats, some girls turn to backstreet abortion or other ways to terminate the pregnancy – which is seen as an easy way to avoid stigma and other negative effects associated with early pregnancy.” – Kenya National Dialogue, 5 December 2017

Stakeholders also highlighted that, to the extent that EUPs are a result of unprotected sex, young people are exposed to the risk of contracting HIV and other STIs. Since many girls drop out of school and/or marry as a result of childbearing, they are often unable to participate in productive activities and therefore unable to provide adequate care for their children or to break the intergenerational cycle of poverty (World Bank, 2015).
School environment and educational consequences

School dropout is a major adverse consequence of adolescent pregnancy and impacts on girls’ right to education. It is highly prevalent, as demonstrated by a study by Birungi et al., which found that over 95% of pregnant learners in Kenya, Malawi, Uganda and Zambia were out of school. School dropout is linked to fewer livelihood options, limited economic independence, and a lack of any additional potential benefits of school attendance, such as increase in self-confidence and life skills. (McCleary-Sills et al., 2013; UNESCO, 2017).

Even in countries that do not have formal re-entry policies, girls, parents, and stakeholders appreciated the necessity and possibility of the girls going back to school after delivery. Indeed, there were cases of some girls going back to school after delivery or girls sitting for examinations while pregnant, including in countries that do not have formal re-entry policies, such as Lesotho and Uganda. Notwithstanding these examples, re-entry is extremely difficult for girls on account of factors such as poverty, stigma and discrimination, and limited support mechanisms for the girls to overcome these.

In addition, many re-entry policies, such as in Malawi, are in a form of government circulars with little direction on rights and responsibilities of different actors to facilitate effective re-entry. An important finding of the situational analysis was that while government and CSO stakeholders displayed knowledge of the existence of re-entry policies, or lack thereof, parents and girls were not able to articulate knowledge of any policy other than showing awareness of the need for and possibility of re-entry.

“Communities are, however, not fully aware of the policy Circular 35 on pregnant learners and school heads are not keen to implement and sensitize learners and communities on the policy.” – Zimbabwe National Dialogue, 14 December 2017

Poverty and the responsibility to take care of the baby also compounds the situation of girl learners who have children as they often lack support and therefore have no choice but to drop out of school. This was demonstrated in Uganda, where young mothers’ groups preferred vocational training to returning back to school as this would help them learn skills that can earn them a living to be able to take care of their children.

“You may want to go back to school but you have a lot of responsibilities (when you have a child). (I need) something I can do to get money. If we can get vocational education like tailoring or hair dressing...” – Young mothers’ FGD, Uganda, December 2017

Similar illustrations emerged in South Africa:

“You don’t go to school after you’ve had the baby... The parents would be like ‘who is going to look after the baby?’ And even besides parents, they can’t pay for you to go to school... it ends up being a burden to your parents. I would also consider that I’m giving my mom a lot of burden until I decide to drop out and go look for jobs or something. Having a baby and being in school... only to those who are lucky...” – Rural out-of-school girls’ FGD, South Africa, December 2017

Stakeholders acknowledged the lack of support for learners with children who want to go back to school. For instance, when discussing the types of bursaries targeted at girls, stakeholders in Kenya noted that:

“(There is)... no support specifically for the pregnant or childbearing girls” – Kenya National Dialogue, 5 December 2017

“Currently there are no special diets for lactating mothers/girls being provided in schools and no provisions for breastfeeding of the children during breaks.” – Kenya National Dialogue, 5 December 2017

The preference to drop out of school and look for vocational training or a job was also reinforced by the fact that many girls who have children felt older than their peers who do not have children and could not comfortably integrate in a school setting.

“Here everyone would wish to go back to school but some of us are now old; I stopped in P7 and right now am 28 and I cannot go back to senior one” – Young mother FGD, Uganda, December 2017

Stigma and discrimination

Adolescent girls who get pregnant face stigma and discrimination at many levels in society, including at school and clinics, as well as within their families and communities. They are considered as “bad examples” to young people and are often called derogatory names, such as “oegere” (“second hand” in Uganda), “ntchembere” (“child-bearing woman” in Malawi), and “Gicokio” in Kikuyu language (“a reject”) in Kenya. They are often ostracized and, in extreme cases, may even be disowned by their families and guardians and expelled from school. At school level, the stigma is perpetrated by both teachers and students.

Stigma affects many girls as they feel ashamed, lose confidence, and withdraw from society, including the school system.

“Now for me (when a girl falls pregnant), society sees you badly if you get pregnant before age, you feel out of place, lose confidence, feel you have to hide or go to the village and not want to stay in that area anymore.” – Urban out-of-school girls’ FGD, Uganda, December 2017

Because of this negative perception of young girls who are pregnant, there seem to be little support from parents and schools to girl learners during the pregnancy, as well as after the pregnancy. When parents accept the situation, especially mothers, they sometimes offer support in terms of guiding the girl through prenatal and antenatal clinic and providing for material necessities for the baby, however, this depends on how soon they accept the situation and whether they have resources to offer some support. In contrast, boys/men who impregnate girls are seldom sanctioned and in some cases are viewed as ‘heroes’.

“They are perceived as heroes, celebrated for proving their fertility and are considered ready to serve and uphold the family name.” – Kenya National Dialogue, 2017
Community and family level

The numerous challenges pregnant girls face range from being ostracized, to bearing the burden of caring for the pregnancy and baby when they cannot afford it. Communities consider pregnancies among young girls as a shame and, in the context of bride price expectations, a loss. It is also common for boyfriends to either deny responsibility of the pregnancy, or just disappear and cut communication with the pregnant girl.

“...when we get pregnant, the first thing at home, parents can easily chase you out of the house; and you go to your boyfriend and yet the boy maybe doesn’t want to marry you that time; and then maybe you go to your friends. Now that process...you have needs yet you don’t have money; you’re not working, you understand? Days of going to labour that’s maybe when your parents can have the sympathy and they come, but after you go away. So also a man can refuse to take care of the child and you have to suffer from the beginning until the baby is born. And taking the kid to school, yet the jobs are scarce.” – Urban out-of-school girls’ FGD, Uganda, December 2017

“Just to add on that, even parents themselves they would be saying, how could you get pregnant at home? You have brought shame to this family and with my friends. So they will chase you away in fear of the community talking about the family. So everyone will be saying so and so’s child is wasted that’s why she got pregnant in her parents’ home...they even look at you as a loss, because they expect something that will come out of you (bride price), but if you just get pregnant, it’s a loss like they may never get anything that will come out of you.” – Urban out-of-school girls’ FGD, Uganda, December 2017

“Pregnant girls are often considered a bad influence in their communities. They are shunned, viewed as deviant, and negatively labelled by society and in their communities. They are perceived as promiscuous; they are victimized and referred derogatively to as ‘mvana’ (a young person having a child out of wedlock) or ‘nzenza’ (a good for nothing/useless person).” – Zimbabwe National Dialogue, 14 December 2017

“When attending a health centre you may find that most pregnant women are grown-ups and they will mock you saying how come you fell pregnant at such a young age. They make one feel out of place and even consider terminating pregnancy.” – Young mothers’ FGD, Lesotho, December 2017

In some cases, the stigma and discrimination is also levelled against the mother or family of the girl who fell pregnant:

“Yhoo! (people would say): ‘Your mother has failed...’ ‘Your mother has not raised you well...’ ‘We have always known this...’” – Rural out-of-school girls’ FGD, South Africa, December 2017

“(when I got pregnant, my dad)... said that I disappointed them and that their friends are laughing at them.” – Young mothers’ FGD, Lesotho, December 2017

“First of all they are no longer going to greet you as they did before. When your mom is with her peers she can’t say anything that people can listen to. Whatever she says they’ll just remind her that her child got pregnant at a young age... Like you can’t say anything if your child has done something like this... It’s like when my mom is sitting with friends like this, there is nothing she can say because they will tell her ‘how can you guide us when you couldn’t guide your own child?’” – Rural out-of-school girls’ FGD, South Africa, December 2017

School level stigma

While EUP often leads to expulsion from school, the shame and stigma that girls face if they return to school may deter them from continuing and completing school. Teenage mothers are often considered a bad influence on their peers, and stigma towards pregnant and parenting girls who do return to school is common. In addition, teachers are often not skilled or willing to respond to the needs of an adolescent mother who may require extra educational support due to the added pressure of child care.

“They (other learners) gave me some strange looks and it even seemed like I’m over age because I was not coming to school the whole year, the next thing they’re assuming I have failed without asking me... (In a whisper) ‘She has failed, it’s because of the baby’... Some would even ask ‘where is the baby, I even thought she had passed on why you didn’t come back after you gave birth...’ They were asking all sorts of questions and I would answer some and to others I thought they just wanted to gossip.” – Rural out-of-school girls’ FGD, South Africa, December 2017

“...because at school they will have expelled you (when you are pregnant)... (when you go back after giving birth)... they look at you like a bad influence, saying that how can you get pregnant in our school, and you are back again? And you are shaming the school.” – Urban out-of-school female youth FGD, Uganda, December 2017

“A girl is expelled from school when they discover that she is pregnant but can be accepted back to school after giving birth. I didn’t return to school after winter holidays because I was six months pregnant and I knew that they were going to expel me once they noticed. They had expelled and humiliated some girls before when they discovered that they were pregnant, so I knew it was going to happen to me.” – Young mothers’ FGD, Lesotho, December 2017

“Girls who re-enrol after giving birth are perceived as a bad influence to the rest of the children, thus hindering girls from going back to school after giving birth.” – Kenya National Dialogue, 5 December 2017

The most reported support to pregnant girls from schools was that some facilitated that they sit for examinations. Some schools wrote the girls reference letters for other schools so they could go to a new environment to avoid stigma and, in some cases, so that they are not seen to tolerate pregnancies in their schools.

Of all the countries under study, despite the stigma, South Africa appeared to be more tolerant of girls who fall pregnant. There were some reported cases of parents being allowed to accompany their pregnant girls to learn, and some schools providing gym facilities to pregnant girls.
Responses to EUP

Regional level legislation and policy

Since EUP affects adolescent girls’ rights to health, education, dignity, and gender equality, the response to it cuts across many sectors and institutions, and there are numerous policies and commitments in ESA that have a bearing on its prevention and management. These are often designed to facilitate and guide adolescent SRHR in the region and are aligned to relevant international conventions and commitments on human rights. In Africa, key instruments that have shaped the response to SRHR challenges, including EUP, are:

- Plan of Action on Sexual and Reproductive Health and Rights (2006)

More recently, the ESA Commitment and related documents confirmed country level support for SRHR, and CSE and EUP in particular, for youth, specifically by committing to:

1. Urgently reviewing and, where necessary, amending existing laws and policies on age of consent, child protection, and teacher codes of conduct.
2. Keeping young people in school, including girls who are pregnant.
3. Initiating and scaling up age-appropriate CSE during primary school as one way of preventing EUPs, among other SRH-related issues.
4. Ensuring that the design and delivery of CSE and SRH programmes includes ample participation by communities and parents, particularly adolescents, young people, civil society and other community structures, including faith-based organizations (FBOs).
5. Integrating and scaling up youth-friendly HIV and SRH services that include safe abortions.
6. Ensuring that health services are youth-friendly.

The ESA Commitment aims to reduce EUP among young people by 75% and increase CSE by 75% in all schools in 21 countries across the region by 2020. For 2015, it set three targets, namely:

1. A good quality CSE curriculum framework is in place and being implemented in each of the 21 countries by 2015.
2. Pre- and in-service SRH and CSE training for teachers, health workers and social workers is in place and being implemented in all 21 countries.
3. Decrease by 50% the number of adolescents and young people who do not have access to youth-friendly SRH services, including HIV, that are equitable, accessible, acceptable, appropriate and effective.

A progress review shows that by 2015, 15 out of the 21 countries reported that at least 40% of primary schools were offering CSE/ Life Skills (UNESCO, UNFPA, UNAIDS, 2016). These included the 10 countries under review in this situational analysis. However, CSE has not been comprehensive enough, as it often does not include pregnancy prevention topics such as condom and contraceptive use, especially at primary school level (Birungi et al., 2014). By 2015, 15 out of the 21 countries had also developed a minimum standard package for youth-friendly SRH. However, the realization of these standards have been marred by various implementation challenges, including inadequate SRH services, conflicting laws, fear and shame, stigma and discrimination, and lack of knowledge of what services are available and where to find them (UNESCO, UNFPA, UNAIDS, 2016).

Additional regional policy documents designed to align to the ESA Commitment are the Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the Southern African Development Community (SADC) Region (2015) and the SADC Parliamentary Forum Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016). The latter aims at giving the SADC member states a rights-based blueprint upon which they can model their laws aimed at preventing and eradicating child marriages, mitigating the effects of child marriage (including EUPs), and raising public awareness on and facilitating monitoring and evaluation (M&E) of child marriages, as well as providing for associated offences and enforcement.

National level legislation and policy

Re-entry policies

Although, as Table 5 demonstrates, appropriate policies for EUP prevention and management are in place or in development in eight of the countries, the major weakness, regardless of the presence of policies, lies in implementation – particularly at local and school levels. At national level, countries are at varying stages of drafting learner pregnancy management policies with specific guidelines. In some cases, such as in Kenya, Malawi and Zimbabwe, policies are still in the form of a circular, hence re-entry guidelines are being developed. No standalone re-entry policies currently exist in Lesotho or Swaziland.

Furthermore, most of the re-entry policies are not backed by specific re-entry enabling laws. In cases of violations, such as expulsion when there is a re-entry policy in place, affected girls have little legal recourse. There are, however, numerous laws that enshrine the right to education, notably national Constitutions.

“Government has been consulting for over five years on a re-entry policy but nothing has happened” – CSO representative, Uganda, 30 November 2017

Tanzania is an extreme case where, despite education policies recognizing the right of children to education, there is a presidential directive that every girl who falls pregnant while in school should immediately be expelled.

“The teacher from Digodigo secondary school began by saying that when the girls are noticed to be pregnant they are straight away expelled from school.” – Tanzania National Dialogue, 18 December 2017

The 20 countries that were present at the ESA Commitment meeting in Cape Town in December 2013, plus Rwanda.
It would seem that expulsion from school and associated stigma leave girls feeling rejected and hopeless, and exposes them to unsafe abortions, early marriage, and poverty, as previously outlined.

“At most circumstances apart from being chased from schools the girls are also chased from their homes and end up living on the streets or taken care by relatives. This increases rate of beggars and street children. She then thinks of abortion through local means because she does not have the money to abort safely – though abortion is illegal. In most cases these girls die from the abortion. In another scenario, the girls are put under early marriages... She agrees to marriage after seeing that school is no more.” – Tanzania National Dialogue, 18 December 2017

Across all 10 countries, barriers to implementation of re-entry policies were lack of coordination and lack of awareness. For example, many policies exist without proper sensitization among target audiences; it was therefore common for girls and some stakeholders to report lack of knowledge of relevant EUP-related policies and laws. This is one reason the Malawi re-admission policy, for example, is said to have not been effective. Efforts are now underway to review and refine the policy. Similarly, many policies are made without putting aside resources to assist in the implementation.

“We have beautiful laws but implementation is a challenge.” – Executive director, Trailblazers Mentoring Foundation, Kampala, Uganda, 30 November 2011

“While the general policy and legislation in the country is strong, the main challenge highlighted is the lack of proper implementation. There is a need for more training and awareness, comprehensive inspections, increased human resources, and enhanced accountability and coordination.” – Namibia National Dialogue, 4 December 2017

“Policy implementation is weak and lacks community awareness and implementation frameworks/guidelines.” – Kenya National Dialogue, 5 December 2017

It would also seem that, in some circumstances, some stakeholders are cautious about how re-entry policies should be implemented. There are suggestions that re-admission of girls who fell pregnant should not pass on a message to other girls that it is okay to fall pregnant while young and in school.

“Keeping pregnant learners and re-integration into the same school; it’s a thin line because it may encourage learners to fall pregnant, it must be managed carefully. What are we saying to those who are taking guidance on abstinence? While calls for learning opportunities no matter what the situation are strong, there is a request to be discreet when managing pregnancy and reintegration.” – Swaziland National Dialogue, 7 December 2017

In practice, even where learner policies exist, most countries approach learner pregnancy from a punitive perspective, where pregnant learners are expelled or banned from returning to their previous school.

The literature supports these findings and shows that re-entry policies are often not consistently applied because of a lack of knowledge at district or school level, or because of arbitrary and context-specific decisions made about their application (UNESCO, 2014). The 2012 analysis of re-entry policies in Malawi, Namibia, Swaziland, Zambia and Zimbabwe by the Forum of African Women Educationalists (FAWE) highlighted the main challenges for implementation related to the lack of training for teachers on how to apply the policies; or to scant action plans, support mechanisms or resources in schools for the implementation; for example, addressing the difficulties in arranging activities or allowing adolescent mothers to breastfeed. Other challenges included cultural norms preventing parents and the community from supporting and appreciating the policies and stigma and discrimination from teachers and fellow students (UNESCO, 2014).

Other relevant national legislation and policies

In some countries, relevant policies, such as those relating to age of consent to marriage, are additional barriers to preventing EUP. For example, in Tanzania and Namibia, girls can consent to marriage at age 15. Moreover, the age of consent to SRH services lacks clarity in many countries. Only in Uganda, South Africa and Malawi is there legislative provision for adolescents to have access to SRH services from 12 years old. As a result, health care providers are left to use their discretion on the appropriate age to access health services, which has created barriers to accessing SRH services by young people. In addition, the absence of legal provision for adolescent girls to use SRH services remains a structural barrier to contraception use, and hence an important driver of EUP.

The ages of consent to sexual activity and to health services are also not harmonized in several countries, creating further barriers to young people accessing SRH services. In Tanzania, for instance, the age of consent to sexual activity is, as with consent to marriage, also 15 for girls, yet the age of consent to accessing HIV testing and counselling services is 18. Such discrepancies have sparked calls for the harmonization of the ages of consent. The fact that many countries criminalize consensual sexual activity among adolescents, as well as HIV transmission, has the potential to increase stigma and discrimination and, thus, further increase adolescent risks of unwanted pregnancies and HIV infection as this means young people may not seek SRH services. South Africa is an exception, where consensual sexual acts are decriminalized as long as the age difference is not more than two years.

Poor monitoring of policies

As reported elsewhere in this situational analysis, school specific rules, regulations, and teacher discretion on EUP management are often not aligned to, and sometimes supersede, national policies and laws. The violation of EUP-related practices and laws speaks to poor monitoring of these laws in many countries.

“How teachers or schools react depends on the level of pregnancy. For instance, if a girl is in her last term of form four, most schools will accommodate the girl to finish her examination. If in any other class/form, she is likely to be expelled from school.” – Kenya National Dialogue, 5 December 2017
"Keeping pregnant learners and re-integration depends on the comfort of the pregnant learner, the student body and administration. Otherwise some schools keep them during pregnancy." – Swaziland National Dialogue, 7 December 2017

"The policies are dependent on the principal; if the principal is negative towards the issue of learner pregnancy, he will decide how it will be treated in his school." – Urban Life Orientation teacher, South Africa, November 2017

Much as there are numerous laws related to different aspects of EUP, such as on age of consent, there are no specific enabling EUP laws, such as on re-entry. This raises a challenge of redress where actors violate such policies. In cases of re-entry policies, stakeholders indicated that learners and their parents can seek redress from education authorities at different levels, from local to national, in cases where learners’ right to re-entry is violated. There was, however, little evidence from the communities that people use these redress mechanisms. This, coupled by lack of awareness of the policies by parents, guardians and girls, resulted in policy beneficiaries who know their right to education but do not know how to claim it, especially in cases of violation.

"Parents are also ignorant about the re-entry policy and do not know who to report to. Another problem is that when teachers impregnate girls the issue is ‘swept under the carpet’. Parents need more information on EUP-related policies. They also need resources for supporting girls who go back to school because the parent needs to take care of the girl and the baby." – Zambia National Dialogue Report, 30 November 2017

CSE provision in schools

In many countries, CSE is embedded in the Life Skills subject in schools. In the 10 countries under review in this situational analysis, CSE at primary school level is often integrated into several subjects in addition to Life Skills, commonly Science and Social Studies. For example, in South Africa and Namibia (Grades 4-7), it is offered as part of Life Skills, while in Tanzania, national dialogue participants indicated that elements of CSE have been introduced in the curriculum from Grades 1-7 through carrier subjects, and more materials are being developed. At high school level in Kenya, Swaziland, Malawi and Namibia, CSE is offered as part of Life Skills and integrated into other subjects, and in Zambia, it is integrated into several subjects. In Lesotho, on the other hand, it is a standalone subject for Grades 7-10, and in South Africa, it is offered through Life Orientation, which is compulsory and examinable from Grades 8-12.

Life Skills Education (LSE)/CSE at both primary and secondary schools is therefore a key programmatic response in the education sector, and should include age-appropriate topics such as growth and development, identity, SRH, gender, HIV and AIDS, assertiveness, self-awareness, sex and sexuality, decision-making and problem-solving, peer guidance, interpersonal relationships, and drug and substance abuse. The teachers interviewed for this situational analysis therefore considered Life Skills not just a mere subject, but supports the development of health behaviours and decision making.

"I want to think that LBSE (Life Skills-based sexuality education) is a single stride in the right direction in preventing EUP!" – High school Life Skills teacher, Lesotho, 23 November 2017

"Life Orientation covers all topics that can help them make informed decisions when it comes to pregnancy and prevention of it." – Urban Life Orientation teacher, South Africa, November 2017

Teacher training efforts in CSE and SRH are underway in the ESA region, for example, in Uganda, Lesotho, Malawi, Zambia and Namibia. These initiatives have demonstrated some collaboration among the education, health and CSO/NGO sectors, and teachers felt that this training equipped them with proper skills to counsel students on SRH-related issues.

While Life Skills is offered in various different ways in schools and teacher training programmes are underway, CSE content may be diluted and, where the subject is not examinable, it may be de-prioritized. In some cases, teachers are uncomfortable and/or unskilled to discuss sexual health issues and may hold religious beliefs that inhibit their involvement in LSE. As a result, some teachers may refuse to teach the subject or may dilute the content by omitting some topics they deem unfit for students at a particular level, particularly sex-related topics. Key informants emphasized the need for teacher selection and training in Life Skills that addresses SRH issues of youth.

‘Another reason (girls get pregnant while young) is lack of proper information about pregnancy and family planning. The lessons that we are given at school are not enough; that is they don’t make proper sense and as girls we mislead each other due to the little information we get from schools. Yes lack of knowledge is the cause." – Young mothers’ FGD, Lesotho, December 2017

While some countries like Lesotho are making Life Skills compulsory, and others like Malawi have made it examinable to “force” teachers and learners to teach and learn this subject, there are trade-offs to this approach, especially in high schools, where making Life Skills examinable may mean students have a choice to drop this subject when they choose subjects to be examined on. On the other hand, making the subject compulsory but not examinable may lead to a casual approach and lack of commitment from both learners and students. There is, however, some evidence indicating that many students at high school enjoy Life Skills because it is exciting and one teacher testified that her students pass this subject better than the other subjects.

The teaching of CSE is also marrered by some conservative teachers who refuse to teach the subject because it is sex-related and it attracts “inappropriate” comments from students, especially at high school. Some Life Skills teachers, especially at primary level, do not agree with the content of the curriculum, saying it is either too explicit or not age-appropriate. Furthermore, many teachers are not trained to teach Life Skills and there is a shortage of teaching personnel in this regard.

“Even though it is part of the school curriculum, it has not been fully implemented. No specific teacher is assigned to teach it, it’s part of science subject; teachers shy off; other have no capacity to teach the subject; and most importantly there are competing priorities for examinable subjects” – Kenya National Dialogue, 5 December 2017
### Table 5: Policy response by country: Learner pregnancy management and prevention

<table>
<thead>
<tr>
<th>Country</th>
<th>Learner pregnancy management policies</th>
<th>Selected relevant legislation and policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kenya</strong></td>
<td>- Re-entry of pregnant girls circular (1998); Re-entry</td>
<td>- Constitution of Kenya (2010)</td>
</tr>
<tr>
<td></td>
<td>- Draft national re-entry guidelines in Basic Education (2017); Aims to provide an enabling environment</td>
<td>- Sexual Offences Act (2006)</td>
</tr>
<tr>
<td></td>
<td>for school re-entry for all learners who drop out of school. Chapter devoted to pregnant</td>
<td>- Children’s Act (2001)</td>
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<tr>
<td></td>
<td>girls and young mothers includes continuation at school as long as health permits; re-entry to same</td>
<td>- Counter Trafficking in Persons Act (2010)</td>
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<tr>
<td></td>
<td>school; sensitization of teachers and learners to respect and support school-going pregnant and young</td>
<td>- Prohibition of FGM Act (2011)</td>
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<tr>
<td></td>
<td>mothers; support from teachers to recover. Responsibilities of school management, parents and</td>
<td>- Person With Disability Act (2003)</td>
</tr>
<tr>
<td></td>
<td>Department of Education outlined; NGOs/FBOs/CBOs to create awareness of policy at community level. The</td>
<td>- HIV and AIDS Prevention and Control Act (2006)</td>
</tr>
<tr>
<td></td>
<td>policy includes a clause that encourages learners to sign a written commitment to return to school.</td>
<td>- Marriage Act (2014)</td>
</tr>
<tr>
<td><strong>Lesotho</strong></td>
<td>No standalone re-entry policy</td>
<td>- National School Health Policy (2009)</td>
</tr>
<tr>
<td><strong>Malawi</strong></td>
<td>- Ministry of Education Science and Technology Re-admission Policy of 1993 (revised re-entry policy</td>
<td>- Constitution, Article 28 (Education for All)</td>
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<tr>
<td></td>
<td>environment for learners to be readmitted to school following drop out due to pregnancy or early</td>
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<td></td>
<td>marriage. Also states that schools need to be free of stigma, and promotes school-based prevention</td>
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<td></td>
<td>measures.</td>
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<tr>
<td><strong>Namibia</strong></td>
<td>Education Sector Policy for the Prevention and Management of Learner Pregnancy (2009): Re-entry and</td>
<td>- Constitution</td>
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<tr>
<td></td>
<td>continuation. Aims for flexibility in managing learner pregnancies. Includes extensive section on</td>
<td>- Adolescent Friendly Health Services National Standards and</td>
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<td></td>
<td>prevention, including age appropriate reproductive and sexual health education to start from Grade 4,</td>
<td>- AFHS curriculum</td>
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<tr>
<td></td>
<td>as per the Life Skills programme. Learner pregnancy management includes support from schools and</td>
<td>- Child Care and protection Act No. 3 (2015)</td>
</tr>
<tr>
<td></td>
<td>families, counselling, and referral to health facility. Pregnant learner can continue at school up</td>
<td>- Combating of Rape Act No. 8 (2000)</td>
</tr>
<tr>
<td></td>
<td>until four weeks before the due date if certified fit by a health care professional. Can return to</td>
<td>- The National School Health Policy (2008)</td>
</tr>
<tr>
<td></td>
<td>school if documentation from social worker (confirm infant cared for by responsible adult) and health</td>
<td>- Education Sector Policy on Inclusive Education (2013)</td>
</tr>
<tr>
<td></td>
<td>care provider, stating learner in suitable state of health. She can return to previous school or</td>
<td>- Education Sector Policy on Prevention and Management of Learner Pregnancy (2010)</td>
</tr>
<tr>
<td></td>
<td>transfer to another school. Policy also has a clause on tolerance, and sections on dissemination/</td>
<td>- National Strategic Framework for HIV and AIDS (2017/18-2021)</td>
</tr>
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<td></td>
<td>implementation and M&amp;E.</td>
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<td></td>
<td>draft policy has provision for an enabling environment, prevention (CSE to be part of curriculum</td>
<td>- The Choice on Termination of Pregnancy Act No. 92 (1996)</td>
</tr>
<tr>
<td></td>
<td>as early as possible as per Life Orientation), care and support to pregnant learners and impact</td>
<td>- The Employment of Educators Act No. 76 (1998)</td>
</tr>
<tr>
<td></td>
<td>mitigation, including continuation in school with medical certificate indicating her due date once</td>
<td>- Promotion of Equality and Prevention of Unfair Discrimination Act No. 4 (2000)</td>
</tr>
<tr>
<td></td>
<td>she is six months pregnant and medical reports if she wishes to stay at school after eight months.</td>
<td>- Child Support Grant as contained in the Social Assistance Act No. 13 (2004)</td>
</tr>
<tr>
<td></td>
<td>The aim is retention in school. The basis for reintegration into school is dependent on medical</td>
<td>- The Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007)</td>
</tr>
<tr>
<td><strong>Swaziland</strong></td>
<td>No standalone re-entry policy: At the discretion of local education authorities (mostly, girls are</td>
<td>- Integrated School Health Policy (2012)</td>
</tr>
<tr>
<td></td>
<td>allowed re-entry.)</td>
<td>- National Contraception Policy Guidelines (2012)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- The HIV, STI and TB Policy (2015)</td>
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</tr>
</tbody>
</table>
### Tanzania
- Presidential directive to expel girls who fall pregnant (2017)
- Draft re-entry guidelines, yet to be approved (in practice, mostly expulsion)

### Uganda
Guidelines for Prevention, Mitigation and Management of HIV and Teenage/Unintended Pregnancy in School-settings of Uganda (2015): Provision for reintegration of young mothers back to school, sex education/Life Skills at secondary school, campaign and create mechanisms for abstinence, create opportunities to understand and make safer sex negotiations, including condom use. In practice re-entry, expulsion or suspension at the discretion of the head teacher.

### Zambia
Ministry of Education Re-entry Policy (1997): Aimed at providing an enabling environment for girls who fall pregnant while in school. The services include provision of counselling, linkage to antenatal services, support and care and mandatory leave when the girl is about seven months pregnant. The girls are allowed back to school six months and not later than a year after delivery. The policy includes a clause that encourages learners to sign a written commitment to return to school. The policy also includes making the school environment safe for learners and prevent pregnancies.

### Zimbabwe
Circular: This circular states that pregnant learners are allowed to take leave from school and that if the young mother (former pupil) wishes to go back to school, or her parents/guardians wish for her to do so, the head of the school at which the pupil was before giving birth shall do everything possible to facilitate her re-enrolment in the same grade/form in which she was before leaving.

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Teachers and stakeholders who were interviewed emphasized the need for training of teachers – especially those who teach Life Skills – on SRH issues among youth. It was observed that many teachers who teach Life Skills are selected largely on the basis of their Social Science qualification and not special training in Life Skills.

“CSE in schools, there should be teachers who are well trained on SRH and not just to teach the knowledge they have obtained from the science textbooks.” – Tanzania National Dialogue, 18 December 2017

Across education sectors in the region it emerged that, at primary and secondary levels, the most prominent policy response that is promoted among learners is abstinence. Even when learners are taught about other preventive methods such as contraception in such subjects as Biology and Life Skills, abstinence is the only component promoted in many schools as a matter of policy.

**Multi-sectoral coordination and linkages between schools and health services**

Many governments harness the power of a multisectoral approach through the use of committees and technical working groups, which draws on the expertise of actors from different sectors. This is potentially effective given the multi-faceted nature of issues such as EUP; however, the functioning of intersectoral structures varies from country to country. It can be marred by weak coordination and poor attendance at meetings, resulting in a lack of continuity, as well as lack of resources.

“The general challenge with these partnerships and coordination structure is functionality. Attendance of meetings is inconsistent coupled with lack of monitoring, follow up and accountability.” – Namibia National Dialogue, 4 December 2017

“This is not a health sector issue alone; we need concerted effort from different ministries. We need a multisectoral approach.” – National Coordinator, AYSRHR, Malawi, November 2017

One area where there has been effective collaboration among the education, health and NGO sectors is the training of teachers in SRH issues, led by the Ministry of Health (MoH) and/or CSOs. There were reports of such trainings in Uganda, Lesotho, Malawi, Zambia and Namibia. Teachers who were interviewed felt that the trainings equipped them with basic skills to counsel students.

At community level, however, there is little coordination, let alone referral between schools and SRH service providers. Most schools do not allow the distribution of any SRH services such as contraceptives, be it from within the school or from external providers. This is congruent with a strong push for abstinence as a pregnancy prevention strategy, with religious schools being even stricter in this regard. South Africa is somewhat more progressive in this respect though, for example, ‘service days’ in schools are organized by NGOs to raise awareness and create excitement and motivation about SRHR issues. Referrals to SRH facilities for contraception and HIV and pregnancy testing take place at these service days.
Pilot districts have also mapped schools to youth-friendly services run by the Department of Health to strengthen referral, but while this appears to be working well, it is yet to be evaluated. Furthermore, although the education policy still emphasizes abstinence, there is some evidence pointing to the fact that teachers and rules become more liberal at high school level, and there is some referral taking place.

“MoGE (Ministry of General Education) mandate does not allow them (schools) to dispense actual services because these are MoH activities, but they can provide the information about where they can go to find the services.” – Zambia National Dialogue, 30 November 2017

“Here at school we give them referral information on where to get sexual and reproductive health services, especially at BLM (NGO clinic); government clinics are not youth friendly.” – Deputy head and Life Skills teacher, urban high school, Malawi, 13 November 2017

“We should advocate for a referral system through which schools will give education and refer students to the health centres for services.” – Tanzania National Dialogue, 18 December 2017

“The Ministry of Education does not have a mandate to distribute condoms but linkages need to be made with the Ministry of Health so that they can provide youth-friendly ways of providing condoms as this falls under their mandate” – Zambia National Dialogue, 30 November 2017

“Schools and clinics must develop a mechanism that will ensure that services are accessible. Referrals are taking place but the system needs to be strengthened; let’s have a tested model that is efficient, traceable and manageable. At the moment we are experiencing a situation where clinics are opened when learners are in school and closed when schools are closed.” – Swaziland National Dialogue, 7 December 2017

CSO interventions

Numerous CSOs run programmes aimed at keeping girls in schools and preventing EUPs. These programmes have included visiting schools to talk to teachers and learners about SRH, as well as the development of manuals to guide girls and teachers on EUPs.

“FAWEZA (Forum for African Women Educationalist in Zambia) trains teacher mentors to work mostly with rural guidance and counselling teacher mentors to provide information on the support a re-entering child will need in school.” – Zambia National Dialogue, 20 November 2017

In South Africa, a national teenage pregnancy campaign is being led by Ibis Reproductive Health, an international NGO. It includes a facilitator’s guide, training manual, and “difficult questions” book for health care workers (HCWs) which focus on how to deal with young people. While yet to be formally evaluated, in schools where it has been implemented, together with partners already working on teenage pregnancy, progress has been noted with zero pregnancies recorded.

School level support

While the school environment is largely hostile to pregnant teenagers and teenage mothers, some schools have specific structures and practices in place to respond to EUPs and related issues. Teachers that were interviewed reported having:

• Student counsellors: Teachers who are trained (often with the support of NGOs) to counsel students on social and health issues.
• Peer educators: Students who help and advise fellow students on SRH (again, often with the support of NGOs). In some cases, girls who fell pregnant and returned to school were trained as peer educators to use their experience to educate others and thereby also fight stigma.
• Mother groups: Groups of mothers who work hand-in-hand with schools to provide advice and counselling to students on diverse issues affecting them, including how to prevent and manage EUPs.
• School nurses: School and CSO key informants recommended the need for a school nurse for each school (as was the case in some boarding schools several years back) to cater for learners’ SRH needs, which would facilitate strong referral mechanism between the education and health sectors.
Situational analysis on early and unintended pregnancy in Eastern and Southern Africa
Section 03

Key findings, recommendations and proposed next steps
Key findings, recommendations and proposed next steps

Summary of key findings

The situational analysis has confirmed that EUP is highly prevalent and increasing in the ESA region, particularly in rural areas. EUP has a severely negative impact on girls’ education, with the majority of pregnant teenagers and teenage mothers never completing school, hence never breaking the intergenerational cycle of poverty, let alone reaching their potential. It is therefore crucial that investments in preventing and responding to EUP in the region are intensified and that effective strategies are adopted.

The findings of the situational analysis support previous evidence indicating that both the problem and solution are multi-sectoral and, therefore, effective collaboration at regional, national, and local levels is essential to the EUP response. Key sectors are education, health, gender, youth, social and economic/labour sectors. While efforts to increase the coverage of high quality CSE is underway in several countries, a lack of appropriately trained teachers and well developed curricula and related resources, as well as negative attitudes by some parents and teachers, hamper these initiatives.

Re-entry policies do exist or are in draft form in most countries, and where they are not in place, related policies support re-entry and school completion. Moreover, some of the draft policies are complemented by guidelines that detail roles and responsibilities in order to ensure greater support for girls in the school setting. Nevertheless, there are many significant barriers to implementation of these policies and guidelines, such as the lack of willingness by heads of schools who believe teenage mothers will encourage EUP among other learners, coupled by widespread lack of awareness by parents, learners and communities of these policies. While learner management policies tend not to be formulated into legislation, recourse to the constitution of a country is likely to support the right to school completion.

The situational analysis found that throughout the region pregnant girls are stigmatized, blamed, and shunned without due consideration for the context or structural factors that increase their vulnerability to an unintended pregnancy. Health service barriers (and resulting limited access to contraception), gender-based violence/sexual coercion, poverty, and cultural norms are some of the contextual factors that contribute to pregnancy. At an individual level, often little responsibility is carried by the male partner, parents/guardians and teachers. Support to teenage mothers – emotional, educational, health and economic – will lead to much better educational outcomes and future life prospects.

Recommendations

The following recommendations are offered at regional, national and local levels.

Regional level

- Intensify advocacy to promote regional agreements, such as the ESA Commitment, by sensitizing countries to the increasing magnitude of the problem and the impact on girls’ education, and hence economic and social development.
- Develop a regional social and behaviour change communication (SBCC) campaign in collaboration with regional stakeholders and partners to address common and cross-cutting themes related to EUP such as:
  - Stigma and victimization of pregnant teenagers, particularly at community, household and school levels;
  - Strengthening parent-child communication about sexual health, and shifting parents attitudes to contraception;
  - Importance of school completion, especially for girls;
  - Increasing knowledge about and use of contraception; including condoms;
  - Building agency and self-efficacy among girls to make healthy decisions about sex and relationships;
  - Shifting norms that promote EUP;
  - Creating enabling and safe environments, especially schools, clinics and communities, for young girls to both prevent and support pregnancy.
- Use multi-media, including TV, radio and social media, for regional and national campaigns. Youth involvement in campaign development is important.
- Continue to support SRHR/CSE capacity-building for teachers, parents and health care workers. Ensure that Life Skills/CSE curricula include strong pregnancy prevention components prior to puberty, and hence start in primary school. A formal assessment of the reach and impact of the UNESCO CSE training would be useful to determine achievements of this intervention, and identify geographic and programme areas that will require consolidation as the training continues.

National level

- Strengthen and adequately resource multisectoral committees/technical working groups that deal with EUPs to tap into the expertise and roles of different sectors that complement each other, such as education, health, police, social welfare, and gender.
- Where still in draft form, develop and finalize learner pregnancy management policies, and create learner pregnancy management policies if non-existent or in circular form. Policies need to be comprehensive by including the rights and responsibilities of different role players, as well as implementation guidelines and mechanisms to manage learner pregnancy.
Situational analysis on early and unintended pregnancy in Eastern and Southern Africa

- Develop policy for compulsory examinable CSE for all senior school learners that includes substantial hours allocated to high quality, age-appropriate sexuality and relationship education. Strengthen Life Skills curricula to extend pregnancy prevention elements in high school and include later years of primary school.

- Develop and/or strengthen existing national EUP campaigns with CSO/NGO and government partners. Campaign materials need to be developed and pre-tested within country contexts.

- Disseminate and train education authorities at different levels in learner management and CSE policies.

- Address relevant policies and legislation that may promote EUP, for example, advocacy to review national legislation that has age of consent to marriage under 18 years, and introduction of policies/legislation that allow youth to access contraception. Strengthen poverty alleviation policies and strategies that target young girls and teenage mothers, such as funding/finance programmes.

- Strengthen M&E frameworks to track pregnant learners to promote re-entry and support, and monitor implementation of learner pregnancy policies.

Community level

- Sensitize communities on learner pregnancy management policies and related policies/laws so that parents are aware that their daughters can re-enter school after delivering the baby, and what support that can be expected at school level.

- Address perception among school staff and learners that pregnant girls are a bad influence on other youth and the school environment. Involve teenage mothers in school-based EUP prevention and support initiatives. Implement school-level training and sensitization of teachers and principals on de-stigmatization and re-entry policies, as well as structured training of teachers on content and delivery of CSE.

- Implement clinic-level training of health care workers on youth-friendly health services (YFHS) and non-judgemental attitudes. To promote utilization of YFHS, ensure appropriate opening times for learners.

- Strengthen referral systems, especially for youth referrals to clinics from schools. This could include mapping closest clinics and regular meetings with schools and clinic staff, while protecting the privacy of the adolescents who seek services.

- Design and support SBCC programmes that build agency and self-efficacy among young girls to empower them to make healthy decisions about their sexual health. Consider peer support and girls’ SRH clubs to support youth SRHR. Sustainability of such programmes will need to be considered.

- Address cultural practices, especially in rural areas, that promote early marriages and early sexual debut through advocacy campaigns and engaging religious and cultural leaders/gate keepers.

- Strengthen parent-teacher associations (PTAs) or similar initiatives to promote positive parenting and to complement home- and school-based initiatives on learner pregnancy prevention and management.

Regional EUP campaign

A regional EUP campaign that adopts SBCC approaches has much potential to address issues common to ESA countries. Such a campaign would be strengthened by national campaigns that carry the same and additional context-relevant messages. Based on the findings of the situational analysis, some of the key areas that could successfully be addressed by a regional EUP campaign are:

EUP prevention

- Shifting attitudes of parents, teachers and communities towards ASRHR;
- Strengthening parent-child communication about sexual health, and shifting parents attitudes around contraception;
- Increasing knowledge about and use of contraception, including condoms;
- Building agency and self-efficacy among girls to make healthy decisions about sex and relationships;
- Shifting cultural norms that promote EUP, such as child marriage.

EUP management

- Decreasing stigma and victimization of pregnant teenagers, particularly at community, household, clinic and school levels;
- Creating enabling and safe environments, especially schools, clinics and communities for young girls, both to prevent and support pregnancy;
- Raising awareness of the importance of school completion, especially for girls.

Proposed next steps

- Disseminate final report findings to UNESCO staff and regional partner organizations, including youth organizations and other regional stakeholders, for discussion and engagement.

- Develop evidence policy briefs for key advocacy themes, such as stigma, CSE, adolescent contraception access, and learner re-entry.

- Develop overarching messages for a regional EUP campaign congruent with national findings, based on situational analysis findings.

- Develop a regional campaign strategy, taking into consideration:
  - Campaign goal and objectives
  - Main messages and secondary messages
  - Which SBCC approaches to use
  - Main target audiences (girls/boys/parents/teachers)
  - Which media to use for different audiences
  - Key elements of an advocacy campaign
  - What the campaign will be called and how it will be branded
  - How campaign elements will be tested
  - Timeframes and budgets
  - Who the campaign partners will be, and their roles
  - How reach and impact will be measured

- Develop national campaign strategies based on the situational analysis and national dialogue reports, led by UNESCO NPOs in collaboration with existing partners and programmes.
Section 04

Country level findings
Country level findings

In this section, specific country level findings are summarized based on the desk review, field work and national stakeholder dialogues.
Kenya

Magnitude and determinants of EUP

The 2014 Kenya DHS estimated that one in three (35%) women in the 15-49 age group experience unintended pregnancy (10% unwanted and 25% mistimed). Nationally, about 18% of teenagers aged 15-19 had ever been pregnant (KDHS 2014) and in a study undertaken in Homabay in 2015 by the Population Council, approximately 66% of out-of-school teenage mothers dropped out of school as a result of unintended pregnancies.

The National Adolescent Sexual and Reproductive Health Policy (2015) highlights various socio-economic and health system factors that contribute to EUP in Kenya, including inadequate youth-friendly reproductive health care services for adolescents, particularly a lack of contraceptive education, as well as a lack of availability and affordability of contraceptives. In addition, a number of human rights violations result in high levels of EUP, including child marriage, coerced sex, sexual abuse and FGM. Despite being outlawed in 2001 by the Children’s Act and the Prohibition of FGM Act 2011, FGM is still a deeply rooted cultural practice in some communities in Kenya. Intergenerational sexual relationships were another key driver of EUP in the country (refer to the section on cultural and gender norms in section 2). In a study conducted among 3,619 unmarried young women aged 15-24 years in urban Kenya (Okigbo et al., 2015), risk factors for earlier transition to first pregnancy were:

- Region of residence (residing in Kisumu and Kakamega, Nairobi);
- Household size (living in a large vs. smaller household);
- Living in a mother-headed household (vs. father-headed);
- Misconceptions about family planning;
- Early sexual debut.

Conversely, having secondary or higher education, belonging to the richest wealth category, use of modern contraception at first sex, and living in Mombasa (vs. Nairobi) were protective factors for teenage pregnancy.

Consequences of EUP

In Kenya, girls who fall pregnant in school face many of the same consequences as those in other ESA countries, including dropping out of school or poor performance in school if they continue, stigma, and trauma. Obstetric complications include maternal death and morbidity, and infant deformities and death. Some pregnant teenagers undergo unsafe abortion to avoid stigma.

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In some instances, girls are allowed to continue with school and sit for exams, especially if they are in the senior class (form four), and in the last term of the school.
Additional consequences include expulsion from school and home, rejection by the boy/man responsible for the pregnancy, poor health due to lack of access to antenatal care, and suffering the burden of bringing up the child. Sometimes girls are married off to older men, especially if the man responsible is influential within the community. Moreover, they are vulnerable to sexual abuse, gender-based violence and intimate partner violence, and may experience labour exploitation. Finally, they may suffer from psychological problems such as low self-esteem and lack of empowerment, and are prone to committing suicide.

Stigma and discrimination against pregnant and childbearing girls

Girls who fall pregnant at an early age are mostly regarded as failures and morally loose, and are often seen as outcasts. Some communities have derogatory labels for girls who become pregnant while young e.g. Gicokio in Kikuyu language (meaning a reject), Kobur in Kalenjin language, and Kiduadi in Luhya language (meaning a girl who falls pregnant before marriage). In cases of sexual abuse such as rape and incest, where the pregnancy is considered really unintended, communities are sympathetic towards the girl. In some communities, especially where adolescent pregnancy is very prevalent, EUPs are considered normal. Allegedly, communities exhibit contrasted perceptions towards boys who impregnate girls; sometimes they are perceived as ‘heroes’, celebrated for proving their fertility, and are considered ready to serve and uphold the family name.

Sources of SRH information for young people

Young people in Kenya mostly get SRH-related information from peers, social media, television and radio, the internet, parents, and teachers. Stakeholders indicated that teachers and parents are the most trusted sources of information for young people, even though in some cases they lack the skills and ability to communicate sexuality-related information due to cultural influence and lack of correct and accurate knowledge. Parents also fear that children may misuse any sexuality information they relay, and will tend to shift the responsibility to teachers. In some communities, sexuality information is taught during traditional initiation practices (rites of passage) where initiates are regarded as young adults who qualify to marry or engage in sexual activities.

National response to EUP

Policy response

Kenya has numerous policies and frameworks/guidelines that address EUP, even though implementation remains a challenge. Some of the existing policies and guidelines include:

- Draft re-entry guidelines (2017)
- Basic Education Act (2013) – re-entry provisions
- National School Health Policy (2009)
- National Adolescent Reproductive Health Policy (2015)
- National Reproductive Health Policy (2015)
- Educational and Gender Training Policy (2015)
- Children’s Act (2001)
Considerations for developing a national EUP campaign

Stakeholders in Kenya provided a number of recommendations for UNESCO to consider during development and implementation of the anticipated national EUP campaign, as follows:

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Specific recommendations</th>
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<tbody>
<tr>
<td>Collaboration and coordination</td>
<td>• Focus on strengthening coordination of existing EUP efforts</td>
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<tr>
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<td>• Build on existing interventions, such as Guidance and Counselling in schools</td>
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<td>• Strengthen the linkage between MoH and MoE to promote SRH information and service delivery</td>
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<td>Advocacy</td>
<td>• Advocate for government to increase resource allocation for EUP programmes</td>
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<td></td>
<td>• Draft and launch school re-entry policy with practical guidelines to aid implementation</td>
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<td>• Disseminate existing policies to increase awareness and ensure enforcement</td>
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<tr>
<td>Research</td>
<td>• Conduct research to collect relevant and reliable data to support lobbying and advocacy campaigns</td>
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<td>• Disseminate findings among relevant stakeholder to inform decision-making and programming</td>
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<tr>
<td>Capacity-building and training</td>
<td>• Integrate Life Skills in the curriculum and build teachers’ capacity to deliver the curriculum</td>
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<td>• Implement programmes focused on orienting teachers and parents to sexuality issues and communication skills</td>
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<td>• Strengthen institutional capacity (for implementing partners) to implement EUP programmes</td>
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<tr>
<td>Youth participation and engagement</td>
<td>• Involve adolescents in all phases of the campaign (planning, development and implementation)</td>
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<tr>
<td>Programmatic recommendations</td>
<td>• Invest in mapping and understanding the socio-cultural and institutional context to inform the design and implementation of the campaign</td>
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<td>• Involve different partners in the design and implementation of the campaign</td>
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<td>• Target all girls (both in and out of school), and enhance male (men and boys) involvement</td>
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<td>• Employ innovative approaches to reach young people</td>
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<td>• Establish the key targets groups, including parents</td>
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<td>• Focus on appropriate messaging and communication for various target audiences and stakeholders</td>
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<td>• Consider utilizing multiple channels to communicate to different campaign audiences</td>
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<td>• Integrate economic empowerment – undertake economic surveys on the role/impact and contribution of EUP in the society (economic impact)</td>
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<td>• Have inclusive systems/responsive programmes – consider including a social protection mechanism</td>
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<td>• Campaign messages should highlight the magnitude of EUP and child marriages in Kenya</td>
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Programmatic response

There are several programmes and interventions addressing EUP implemented by government (MoE), CSOs and FBOs at national and county levels, including the following:

<table>
<thead>
<tr>
<th>Government initiatives</th>
<th>CSO/FBO initiatives</th>
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<tr>
<td>• Life Skills mainstreaming in the basic education curriculum</td>
<td>• Teacher training programmes (gender responsive pedagogy and Girl Guides movement)</td>
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<tr>
<td>• Guidance and counselling in schools</td>
<td>• Vocational training (enrolling girls who drop out of school into vocational training centres)</td>
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<td>• Gender Units established</td>
<td>• Rescue services for girls who have been married off</td>
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<tr>
<td>• MoE circular Re-enrolment</td>
<td>• Research and documentation</td>
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<tr>
<td>• Allowing pregnant girls to sit for national exams</td>
<td>• Linkages between schools and health services and referral systems</td>
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<td>• National Schools Sanitary Programme</td>
<td>• School and community sensitization on ASRHR and EUP among the girls</td>
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<td>• Establishment of sanatoriums and placement of school nurse in boarding schools</td>
<td>• Scholarships for teenage mothers</td>
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<td>• Establishment of rescue centres/boarding schools for girls in environments with high prevalence of child marriages</td>
<td>• Advocacy and lobbying for high-level leadership support to efforts on ending EUP</td>
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<td>• Youth-friendly services by MoH</td>
<td>• Provision of free sanitary towels and scholastic materials to needy girls in schools</td>
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<td>• National Public School Feeding programme (not specifically for pregnant girls)</td>
<td>• Youth-friendly centres/services</td>
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<td>• Introduction of modern/alternative rites of passage</td>
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Lesotho

Magnitude and determinants of EUP

According to the 2014 DHS, 19.1% of women in Lesotho aged 15–19 years have ever been pregnant, with a marked urban/rural difference, at 11.7% and 22.5% respectively. More than half (56%) of early pregnancies were unintended. Half (50%) of girls who had only completed primary school were ever pregnant, compared to 17.3% who completed secondary school. Those from poorer families were more likely to have been pregnant (28.3%), compared to those from better-off families (5.8%). A recent qualitative study found that poverty was identified by learners, principals and parents as a major driver of EUP. (Sexual Gender-Based Violence Restoration Unit, 2018). While 42% of women had sex by the age of 18, only 19.7% of adolescents were on modern contraception.

As is the case across the ESA region, young girls from Lesotho are vulnerable to peer pressure and transactional and intergenerational sex, which can introduce power imbalances and condomless sex.

“Mostly it is peer pressure because in most cases we don’t normally date our age groups, we are attracted to guys who are employed only to find that we don’t have a say in that kind of a relationship. An older guy will be spoiling me with gifts and when comes a time whereby he wants us to be intimate, I can’t refuse and say that he is older than me because he will state that he does everything for me and he may even refuse to use a condom saying that his gifts come unwrapped and I can’t expect him to use a condom in return.” – Young mothers’ FGD, Lesotho, December 2017

Lack of parenting skills to communicate with youth has also been identified as a factor contributing to EUPs.

“Sometimes our parents do not disclose these issues to us and we fall pregnant without knowing about them. I think it is necessary for parents to talk to their children about sexual and reproductive health issues.” – Urban out-of-school girls’ FGD, Lesotho, December 2017

“We as parents fail to talk to our children about the use of contraceptives and we also don’t make them aware of the consequences of unprotected sex.” – Parents’ FGD, Lesotho, December 2017

A recent study found that female learners who reside on their own in rented accommodation are vulnerable to unprotected sex, since there is a lack of adult supervision. (Sexual Gender-Based Violence Restoration Unit, 2018).

Stigma and discrimination against pregnant and child-bearing girls

Stigma was experienced at school, family and clinic levels, where the pregnancy was considered shameful. This can lead to girls opting for unsafe abortions.
“Stigma might also lead to unsafe abortion. When one hears those humiliating hurting things about her they resort to abortion. And this is a challenge on its own as we often go to back street abortions and die.” – Urban out-of-school female youth FGD, Lesotho, December 2017

“When attending a health centre you may find that most pregnant women are grown-ups and they will mock you saying how come you fell pregnant at such a young age. They make one feel out of place and even consider terminating pregnancy.” – Young mothers’ FGD, Lesotho, December 2017

“One of the greatest challenges facing young adolescent girls is the fact that the majority of schools still expel and humiliate learners who fall pregnant. These girls have to stay home while other young girls are back at school. They then become social outcasts and socially withdrawn. Some of these children could be very bright, but by falling pregnant and having babies, they end up working in households.” – CSO KII, Lesotho, December 2017

National response to EUP

Policy, legal and programme response
Lesotho does not have a formal school re-entry policy following childbirth. There are, however, some policies that have a bearing on keeping learners in school and improving their health. These include the Lesotho School Health and Nutrition Policy, the National Youth Policy (2003), and the Education Policy, which has provision for the re-entry of pregnant girls/teenage mothers, but is not widely applied and lacks legal backing. In practice, pregnant teenagers are often expelled from school.

“A girl is expelled from school when they discover that she is pregnant but can be accepted back to school after giving birth. I didn’t return to school after winter holidays because I was six months pregnant and I knew that they were going to expel me once they noticed. They had expelled and humiliated some girls before when they discovered that they were pregnant, so I knew it was going to happen to me.” – Young mothers’ FGD, Lesotho, December 2017

Although a recent study found that expulsion is less common than previously, some schools continue to expel pregnant girls since they believe pregnant learners negatively impact on other learners and schools are unable to provide the required support. (Sexual Gender-Based Violence Restoration Unit, 2018).

CSE/LBSE
Lesotho has made strides in the development and implementation of Life Skills-based sexuality education (LBSE), the equivalent of CSE. Schools teach LBSE to equip learners with skills that will enable them to avoid or delay sexual debut, resist peer pressure, and negotiate safe sexual encounters as the last resort. LBSE has been piloted in Grades 8-10 in 70 primary schools and 100 secondary schools (Molapo, 2016).

In an effort to link the education and health sectors to offer learners with referral SRH services, Lesotho has also enrolled 237 teachers, 50 nurses and 40 education officers in an online CSE course (Molapo, 2016). Challenges of the LBSE are that:

- There are still not enough teachers to teach this subject despite training;
- There are issues of confidentiality and trust between learners and teachers, particularly if the LBSE teacher also teaches other subjects;
- The subject is not assessed and therefore some teachers, including principals, undervalue it.

CSO programmes
CSO programmes addressing EUP in Lesotho include the Lesotho Planned Parenthood Association, Kick4Life, and Youth Hub.

Proposed interventions

- Parenting programmes
- Youth corners in health services
- Peer education programmes
Malawi has high fertility rates and high rates of early childbearing, with 29% of 15-19-year-olds having had a child or been pregnant, 41% of which are unintended. More than half (54.1%) of young women with no education have started childbearing (DHS, 2015).

In a study conducted by Hall et al. (2016) to determine risk factors for unintended pregnancies in Mchinji district, 4,244 pregnant women were asked about their pregnancy intention, socio-demographic characteristics, and obstetric and psychiatric history. The study found that increased socio-economic status was associated with increased pregnancy planning and intention, while previous depression or abuse in the last year or at a younger age were associated with lower pregnancy intention. In Zomba district, socio-cultural factors contributing to unplanned teenage pregnancy were investigated through interviews conducted with 505 young women under the age of 20 years at five antenatal clinics (Kaphagawani et al., 2017). The study found that a staggering 76% of the teenagers reported an unplanned pregnancy. Factors that contributed to the high rate of teenage pregnancy were early sexual debut and marriage, low contraceptive use, low educational levels, low socio-economic status, and lack of SRH knowledge. Gender issues were also associated with unplanned pregnancies, specifically gender inequity and physical/sexual violence. Serious consequences of unplanned teenage motherhood was noted and the authors recommended a multisectoral approach to responding to the problem. A World Bank policy brief overview (2016) has outlined some of the economic determinants of child marriage and teenage pregnancy in Malawi, including the inability of families to bear the costs of girls’ education and limited options for girls to generate income to enable themselves and their families to move out of poverty.

In a qualitative study in rural Malawi which explored parents’ perceptions of sexual activity and adolescent pregnancy (Grant et al., 2012), sexual activity was seen as a threat to educational attainment, since pregnancy and dropping out of school was considered inevitable if a daughter was sexually active. Parents were concerned that if their teenage daughter wanted nice things that the parent could not afford, she would be more vulnerable to having sex since exchange of gifts and money for sex among adolescent sexual relationships was considered normative. In some cases, in view of the threat of sexual harassment from teachers, schools were not considered safe environments for daughters. This was seen in conflict with the aspiration for school completion. The lack of resistance to dropping out of school among very poor families could be explained by a need to shift educational resources between children and/or to household needs.
National response to EUP

Policy and legal response
The Ministry of Education, Science and Technology (MoEST) Re-admission Policy was approved in 1993, followed by the school re-admission guidelines in 2006. Nevertheless, despite the policy and guidelines that were meant to curb school drop-out rates among girls, especially those who fell pregnant, the school drop-out problem persists. The implementation of the policy is affected by the fact that the policy remains punitive and reactionary. There is also a lack of clarity about the re-admission process; and where utilized, the process often proved to be lengthy and cumbersome for the learner seeking re-admission. Moreover, there are no implementation or M&E plans attached to it, and religious leaders and school principals are sometimes opposed to re-entry (World Bank, 2016). In addition, those that return may have several needs, including child care support, lower school fees, cash transfers, SRH service access, and mentorship – and it is not clear if these are addressed at school level. This has necessitated the revision of the policy.

By 2017, the revised policy was still in draft form; however, it commits to design CSE beyond the mere teaching of Life Skills in primary and secondary schools as one way of preventing EUPs. Although there is no one legislation that acts as an enabling law for the policy, different aspects of the policy may find legal backing from the Malawi Constitution that guarantees education to all and non-discrimination, and recently raised the age of consent to marriage to 18 years. Other EUP-relevant laws include the:

- Education Act (2013)
- Gender Equality Act (2013)
- Child Care, Protection and Justice Act (2010)
- Marriage, Divorce and Family Relation Act (2015)
- National Girls Education Strategy (2014), which aims to advance girls’ education and tackle the barriers that girls face in terms of their participation and access to education in comparison to boys.

Programme response
There are numerous programme responses run by different donors and organizations aimed at preventing and managing EUPs. These include the:

- Forum for African Women Educationalists in Malawi (FAWEMA) programmes advocating for the re-entry to school of girls who have been pregnant;
- UN Girls Education Programmes piloted in Dedza, Mangochi and Salima districts that aim to promote poverty reduction through improved quality education and basic life skills for adolescent girls;
- UNFPA programmes on youth-friendly SRH services;
- UNESCO initiatives on CSE/LSE.

The government of Malawi has also embarked on some programmes (sometimes in collaboration with CSOs) to address adolescent SRH issues. These initiatives include:

- Adopting a strategy to open up access to SRH services to young people (10-24 years);
- Capacity-building for service providers (e.g. medical workers, teachers, police officers, etc.) to provide youth-friendly SRH services;
- Capacity-building for youth community-based distribution agents (CBDAs) who get non-prescriptive SRH supplies, such as contraceptives, from clinics and distribute them to young people in communities;
- Community outreach programmes;
- MoE LSE for young people in schools;
- Ministry of Youth CSE programme for out-of-school young people;
- Initiatives to end child marriages (some of which are being implemented by traditional leaders).

Recommendation from stakeholders

- Train more teachers and health workers to facilitate referral mechanisms from school to health facilities;
- Increase the use of youth-friendly SRH services;
- Promote positive parenting;
- Involve FBO initiatives aimed at preventing and managing EUPs.
Situational analysis on early and unintended pregnancy in Eastern and Southern Africa

**Magnitude and determinants of EUP**

EUP is a huge challenge for Namibia with a pregnancy and childbearing prevalence of 19% among girls aged 15-19 years in 2013. This represents an increase in the proportion from 15% in the 2006/07 NDHS survey. Notably, 40% of the pregnancies in this age group were a result of non-consensual sex. Teenage pregnancy is more than three times higher among young women in the lowest wealth quintile than those in the highest, and is more pervasive in certain regions in Namibia; three regions (Kavango, Kunene, and Omaheke) accounted for more than one-third of teenage pregnancies reported during the DHS 2013 survey. The survey also revealed that 14% of women are married by 20 years old, 5% have had sexual intercourse by the age of 15, and 62% have had sexual intercourse by the age of 20. The EUP prevalence among 10-14 year olds is not known due to data disaggregation challenges, however, school dropout rates in Namibia are aggravated by teenage pregnancies, as reflected in the Ministry of Education, Arts and Culture (MoEAC) Education Management Information System (EMIS) data, which reported that the number of girls who dropped out of school due to pregnancy increased from 1,431 in 2011 to 1,881 in 2015.

UNICEF (2016) reported that the factors that contribute to high rates of teenage pregnancy in Namibia include traditional norms which accept and celebrate teenage pregnancy, low levels of education, limited information about and access to contraceptives, sexual abuse as a consequence of physical and financial vulnerability, non-consensual sex with students or teachers, alcohol abuse by learners which could result in risky sexual behaviour, and teachers who abuse their positions of authority.

Teenagers also lack information about sexuality because, although CSE is part of Life Skills, delivery may not be optimal. In addition, parents are unable to educate their children about sexuality because they lack resources, are unsure of what to say, or because they feel uncomfortable discussing it with them. Schools and peers are therefore considered to be the main sources of information about sexuality for teenagers; many teenagers perceive their peers to be more approachable, and information sharing about sexuality may also be more spontaneous. However, this strong peer influence may compromise teenagers’ knowledge of sexuality, and therefore their decisions regarding sexual behaviour.

**Stigma and discrimination against pregnant and child-bearing girls**

Girls who fall pregnant at school are believed to be promiscuous, are blamed and labelled. While some families are supportive of young pregnant learners, others respond by disowning them. Their peers often tease them and refer to them as “Life Skills teachers’ learners” or “mothers”. Some learners take it upon themselves to provide protection and support to their pregnant colleagues. While Life Skills teachers are generally the most supportive, other teachers mostly gossip about pregnant learners. Learner fathers receive reactions that are very different from the girls, ranging from disappointment to indifference in the community, and even hero status among their friends.
Sources of SRH information for young people
In Namibia, young people experience difficulties accessing SRH information from health centres because of the lack of truly adolescent-friendly services. It is believed that they mainly get SRH information from their peers, the internet, brochures and magazines such as the OYO magazine (by local NGO Ombetja Yehinga Organization), Life Skills teachers, life coaches, and peer educators where available. While a recent United Nations Population Fund (UNFPA) report indicated that young people stated parents as their trusted source of SRH information, stakeholders from national dialogues were of the opinion that young people hardly approach their teachers or parents for SRH information.

Linkages between schools and health services
SRH services are generally not available for children in schools. This is mainly because of challenges with issues of parental consent. An example is HIV testing, where people below the age of 14 require parent/guardian to consent on their behalf. Contraceptives and condoms are also not provided in schools due to sensitivities at community level. SRH services for learners are limited mainly because of resistance by some principals, teachers, and parents. Linkages between schools and SRH services are also lacking; in as much as learners are getting information on SRH as well as where to access services, the referral system is informal and weak. Most referrals are to Ministry of Health and Social Services (MoHSS) and Namibia Planned Parenthood Association (NAPPA) facilities, but no feedback on referral completion is sought or provided. Post-referral follow-up is not routinely provided. The country needs a CSE minimum package for schools, including referrals, to be established and clearly communicated.

National response to EUP

Policy response
Existing policies and strategies that address EUP in Namibia include:

- Education Sector Policy on Prevention and Management of Learner Pregnancy
- CSE curriculum as part of the Life Skills programme
- Adolescent-friendly health services (AFHS) National Standards
- National Guidelines on Adolescents Living with HIV (AL-HIV)
- AFHS curriculum
- National Strategic Framework on HIV and AIDS 2017/18-2021/22
- Child Care and Protection Act No. 3 (2015)
- Combating of Rape Act No. 8 (2000)
- National School Health Policy (2008)
- Education Sector Policy on Inclusive Education (2013)

Re-entry policies and support
In Namibia, pregnant and childbearing girls in school are allowed to continue with school as well as re-enter after delivery through the Learner Pregnancy Policy that was approved by Namibia’s Cabinet in 2009. The policy allows pregnant learners to continue with school until four weeks before delivery, and resume school after delivery, provided they have a certificate of fitness by a health care worker. School boys responsible for pregnancies are allowed to continue with school uninterrupted.

Participants from the national EUP dialogue agreed that awareness of the policy among teachers, parents and learners is piecemeal and its implementation is inconsistent. Some stakeholders, including parents, openly oppose the Learner Pregnancy Policy because they feel it is too lenient and appears to promote early sexual debut and early pregnancies.

Policy implementation is variable as people have different beliefs and feelings about it. There is no legislation in place compelling young mothers to be re-integrated in the school system. Support to learner fathers and mothers is provided by Life Skills teachers as well as CSOs working in schools. This mostly consists of psycho-social support and parenting information. The UNICEF (2016) study showed that most of the adolescents who drop out of school as a result of pregnancy fail to return to school, due to financial constraints and stigma.

CSE intervention
CSE is comprehensively taught to learners in Grades 4-12 as well as at primary school level. There are, however, some challenges with actual CSE implementation because some teachers tend to prioritize promotional subjects, of which CSE is not. As a result, personal values and attitudes often negatively impact implementation. The different approaches used to teach sexuality in schools include classroom sessions; boys’ and girls’ clubs and talks; counselling sessions; My Future My Choice (MFMC); and the Window of Hope programmes.

Considerations for developing a national EUP campaign
The major gaps identified in Namibia’s implementation of the EUP response are as follows:

- Lack of a comprehensive, nationwide EUP programme;
- Lack of AFHS;
- Lack of sufficient efforts to engage parents on SRH for adolescents and young people;
- Lack of standardized referral tools and procedures between schools and service providers.

Recommended approaches and themes:

- Strengthen AFHS by training more service providers;
- Provide SRH services at times convenient to learners;
- Use social media to appeal to young people with SRH messaging;
- Rebrand CSE as a promotional subject;
- Develop SRH referral tools and standard operating procedures (SOP) to improve linkages between schools and services;
- In designing and implementing a national EUP campaign in Namibia, involve key stakeholders such as parents, traditional and religious leaders, other community gatekeepers, as well as adolescent girls and boys.
Programmatic response
There are a number of EUP programmes in Namibia, implemented by the government and civil societies. They are summarized below:

<table>
<thead>
<tr>
<th>Institution</th>
<th>Specific interventions</th>
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<tbody>
<tr>
<td><strong>Government</strong></td>
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</table>
| MoEAC 3 | - Community mobilization and advocacy campaign to mobilize gatekeepers (church leaders, traditional leaders, parents, CSOs, parliamentarians and principals) on CSE  
- My Future My Choice programme  
- Sensitization of community leaders on Learner Pregnancy Policy  
- Learner mother’s empowerment workshops and sponsorships to return to school  
- Integration of CSE into Life Skills curriculum  
- Implementation of CSE through the Prevention and Management of Learner Pregnancy Policy  
- Capacity-building for teachers through training of pre- and in-service life skills on delivery of CSE  
- Provision of sanitary towels  
- National School Health Programme |
| MoHSS | - BCC, radio programmes  
- Plans to roll out a national EUP campaign, in partnership with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), in 2018 |
| Ministry of Gender Equality and Child Welfare (MoGECW) | - Permanent Taskforce on Children |
| **CSOs** | | |
| Star For Life | - Girls and boys clubs, workshops, edutainment  
- Campaigns, classroom sessions  
- BCC |
| Forum for African Women Educationalists in Namibia (FAWENA) | - Campaign – empowerment workshops for vulnerable girls  
- Provision of sanitary pads  
- Programmes with in- and out-of-school youth |
| LifeLine/ChildLine (Omaheke, Oshikango, Kavango East, Kavango West) | - Gender-based violence line  
- Radio programme on CSE (in-schools, training workshops in EUP)  
- Counsellor sessions in communities (targeting boys)  
- Programmes on education |
| Project Hope (Onandjokwe, Oshikuku, Khomas) | - Household programme with caregivers and parents, individual education on CSEs  
- SRH demand creation programme |
| African Youth and Adolescents Network (AfriYAN) | - Advocacy campaigns  
- “Do not kiss and tell” TV series |
| NAPPA | - Adolescent-friendly reproductive health clinical services  
- CSE |
| **Advocacy** | | |
| Be Free movement | Advocacy network led by the office of the first lady that addresses adolescent SRH in Namibia |

3 The MoEAC leads implementation of programmes that target adolescents and young people in schools.
Magnitude and determinants of EUP

South Africa has lower rates of teenage pregnancy than other countries in the ESA region, at 15.6% of young women aged 15-19. The 3rd South African National Youth Risk Behavioural Survey (2013) found that among female learners who had sex, 22.2% had ever been pregnant, 18% had given birth, and 8.4% had undergone an abortion, of which 34.4% were in a hospital or clinic (Reddy SP et al.). Another study, conducted among 2,675 high school students in rural KwaZulu-Natal, found the overall prevalence of pregnancy was 3.6%, with the highest rate (7.2%) being among females aged 18-19 (Abdool Karim & Kharsany et al., 2014). Although sexual activity among adolescents has decreased from 41.9% in 2002 to 36.9% in 2011, pregnancy among girls who had ever had sex increased from 17.3% in 2008 to 21.3% in 2011 (Jonas et al., 2016). A cross-sectional study conducted among 3,123 participants aged 18-24, from four of nine provinces in South Africa (Eastern Cape, Gauteng, KwaZulu-Natal and Mpumalanga), found that 19.2% of female youth had an adolescent pregnancy, while 5.8% of male youth had impregnated a girl when they were an adolescent. In addition, 16% of the young women indicated that they ever had an unwanted pregnancy, and 6.7% had ever terminated a pregnancy (Mchunu G et al., 2012).

In the South African context, some teenage pregnancies are desired, but most are unplanned or unwanted. In a longitudinal study conducted among a cohort of 1,416 young women aged 15-26 in the Eastern Cape, there were 174 pregnancies, of which only 10 (3.6%) were wanted. Of the 164 remaining pregnancies, 53 (32.3%) were unplanned and 85 (67.7%) were unwanted (Christofides, 2014). The National Income Dynamics Study (NIDS), which examined the relationship between teenage childbearing and schooling outcomes, found that 35% of women aged 20-34 in 2010 gave birth as teenagers (Timaeus & Moultrie, 2015), while other evidence shows that between 1996 and 2001, teenage fertility declined by 10%, from 79 births per 1,000 women to 65 births per 1,000 women (Christofides et al., 2014).

Lower educational achievement and a “shock” to the household – defined as death of a household member, job loss, marital disruption, or loss of a grant or remittance – have been identified as risk factors for teenagers becoming pregnant (Christofides et al., 2014). In the Eastern Cape physical abuse was associated with adolescent unwanted pregnancy, young women who experienced physical abuse were more likely to report a new unwanted pregnancy.

Risk factors identified in a secondary analysis of South African National Youth Risk Behaviour Surveys (YRBS) data include:

- Early sexual debut (sexual debut by 13 years or younger);
- Having two or more sexual partners;
- Having ever used alcohol before sex;
- Substance use (smoking cigarettes, binge drinking and using mandrax);
- Race (being white lowering the odds of ever being pregnant);
- Coerced sex (ever been forced to have sex).
A cross-sectional survey in six urban and rural health districts of three South African provinces among 447 sexually-active girls aged 10-19, found that engaging in age-disparate sex and long-term school absences were also associated with higher rates of adolescent pregnancy (Toska et al., 2015). Reporting on other studies, Toska et al. list the following factors associated with increased vulnerability to early unwanted pregnancy in South Africa:

- Early sexual debut;
- Gender-based sexual violence;
- Having older sexual partners;
- Forced sexual initiation;
- Experiences of physical abuse;
- Lack of or limited use of condoms;
- Unequal gender relations;
- Poor partner communication;
- Coercive sex.

Conversely, among 1,416 young South African women (15-26 years) in the Eastern Cape, use of hormonal contraception and higher socio-economic status were found to be protective against adolescent unplanned pregnancies (Christofides et al.) Consistent condom use and school enrolment were associated with lower rates of adolescent pregnancy in three provinces (Toska et al., 2015).

A qualitative study conducted among 325 young unmarried women aged 15-30 years who had given birth before the age of 20 in the North West Province (Mturi, 2015) found that the pregnancies were mostly unintentional, and occurred as a result of a lack of information on reproductive health. Other risk factors for EUP included external (partner, family and peer) pressure, incorrect and inconsistent use of contraceptives due to lack of information, and experiences of rape.

Stigma and discrimination against pregnant and childbearing girls
Teenagers who become pregnant in South Africa are highly stigmatized and are sometimes seen as immoral. This is prevalent in both schools and communities (Timaeus, 2015). Schools and educators are often unsupportive and respond negatively to teenage pregnancies. It is not surprising, therefore, that studies from South Africa show a strong relationship between teen pregnancies and poorer educational outcomes (Christofides et al., 2014). Similarly, Mashishi and Makoelle assert that teenage pregnancy is highly stigmatized in African communities, and adversely affects a teenager in many ways, including dropping out of school. A secondary analysis of the NIDS data from 2008 and 2010 found that girls who gave birth had twice the odds of dropping out of school, and nearly five times the odds of failing to matriculate.

National response to EUP

Policy response
The Department of Basic Education has a draft National Policy on Prevention and Management of Learner Pregnancy (2016), which, together with other instruments such as the Constitution and the Schools Act (number 84 of 1996), mandates re-entry of learners who fall pregnant and promotes CSE in schools to manage and prevent EUPs. The National Sexual and Reproductive Health and Rights Framework Strategy (2015) further speaks to strengthening CSE and access to SRHS for adolescents and youth and advocates for a multisectoral approach to addressing youth needs, while the National Adolescent and Youth Health Policy (2017) provides details for delivery of YFHS. However, in reality, implementation of policies varies between provinces and from school to school. Some schools ignore the policies and expel girls who become pregnant. In many instances, teenagers are forced to give up their education in order to take care of the baby. In the North West province, for example, Mturi found that even though pregnant girls are legally allowed to stay in school until they deliver, and return to school after delivery, this is not reflected in practice. Some girls reported being refused re-entry into school after delivery.

Programme response
There are numerous programmes in South Africa aimed at preventing and managing EUPs. One such programme, implemented in 10 districts, is the Keeping Girls in School project, funded by the Global Fund. This project aims to decrease new HIV infections among young women, decrease teenage pregnancies, and retain girls in school until completion of high school (Global Fund, 2016). Another notable programmatic response is ‘She Conquers’ – a national campaign aimed at empowering adolescent girls and young women. The key objectives of this campaign are to:

- Decrease new HIV infections in girls and young women;
- Decrease teenage pregnancies, in particular the number of deliveries in girls less than 18 years old;
- Keep girls in school until matric and increase the retention of adolescent girls and young women in school;
- Decrease sexual and gender-based violence among adolescent girls and young women;
- Increase economic opportunities for young people, particularly for young women.

Other programmes include the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) project in KwaZulu-Natal, the Mmoho campaign led by Ibis Reproductive Health.
Swaziland

Magnitude and determinants of EUP

Swaziland is experiencing heightened dropouts in both primary and secondary schools due to pregnancy. The Annual Education Census revealed that out of 1,951 girls who dropped out in 2015, 862 were a result of pregnancy, and boys who impregnate girl learners were also reportedly forced to drop out of school. While poverty is a key driver for sexual activity in young girls (refer to the section on socio-economic and demographic drivers in section 2), young men, on the other hand, are encouraged by peers to sleep with many girls to prove their manhood. In addition, for some, disposable income (pocket money) encourages them to indulge in drugs and alcohol, which influences risky sexual behaviours such as unprotected sex. Parents also contribute to the EUP problem, as they are unable to provide guidance to their children, and instead shift the responsibility to teachers.

“Let’s agree that there are no parents... Some parents are teen parents themselves.” – Swaziland National Dialogue, 7 December 2017

Participants of the National Dialogues expressed that they felt the church is equally not doing much to support the prevention of EUPs.

“Learners got pregnant carrying their bibles, what is the church doing given they are authorities of morals and marriage officers?” – Swaziland National Dialogue, 7 December 2017

Stigma and discrimination against pregnant and childbearing girls

Stigma against pregnant young girls and teen mothers is prevalent in Swaziland, as communities feel that teen mothers will corrupt the rest of the teens in the community. There was a suggestion to bring back traditional fines for impregnating a girl before marriage.

Linkages between schools and health services

Schools only provide CSE as part of LSE, and while there does exist a linkage between the MoET and MoH, there is room for improvement; referrals between schools and health facilities are happening, but the system needs to be strengthened.

Currently, most clinics in Swaziland are open when learners are in school, and close when schools are closed. National stakeholders recommended that schools and clinics develop and pilot an efficient model/mechanism that will ensure that services are accessible. Young people who participated in the national dialogue requested for condoms to be made available in schools. However, the majority of participants felt that it is not the school’s or MoET’s mandate to offer condoms.
National response to EUP

Policy response
Swaziland does not have a standalone school re-entry policy. The Swaziland Education and Training Sector Policy (2011) does, however, indicate that every child, irrespective of their life circumstances, has the right to be re-integrated into the same institution that they were previously attending. The Ministry of Education and Training (MoET) has also developed a Life Skills syllabus that includes sexuality education as a standalone and integrated subject (Swaziland Government, 2012). For instance, for secondary schools, the themes include Guidance and Counselling, HIV information, and health promotion. Existing policies and guidelines that address EUP in Swaziland include:

- Extended HIV National Strategic Framework
- Poverty Reduction Strategy
- National Development Strategy
- Inqaba Care and Support for Teaching and Learning (CSTL) Framework
- Education and Training Sector (EDSEC) Policy (2011)
- Reproductive Health Policy and Strategy
- National Gender Policy

Programmatic response
The table below presents some of the interventions implemented by government to address EUP in Swaziland:

<table>
<thead>
<tr>
<th>Institution</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>MoET</td>
<td>LSE curriculum</td>
</tr>
<tr>
<td>MoH</td>
<td>Provides adolescent- and youth-friendly health services (AYFHS)</td>
</tr>
<tr>
<td>Ministry of Sports, Culture and Youth Affairs</td>
<td>Provides CSE for out-of-school youth through Swaziland National Youth Council (SNYC)</td>
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</table>

Education sector response

CSE
In an effort to prevent EUP, the MoET, in collaboration with other line ministries and CSOs, is implementing the LSE curriculum under the HIV, Gender and Life Skills pillar of the CSTL Framework in all schools. The curriculum covers issues of empowerment, SRH, communication, HIV and AIDS, and gender, as well as career planning.

Re-entry policy
The EDSEC policy facilitates re-entry of girl learners who fall pregnant back into the school system after they have delivered. It explicitly states that “every child, irrespective of their life circumstances, has the right to be re-integrated into the same institution that they were previously attending.” However, in reality, this policy is not widely known, and hence there is a gap between policy and practice. Implementation of the policy varies from school to school, and keeping pregnant learners in school usually depends on the comfort of the pregnant learner, the student body, and administration. The common practice for re-admitting young mother learners into the school system is to transfer or re-enter them in another school, including non-formal education because there is a perception that keeping pregnant learners and re-integrating them into the same school may encourage other learners to fall pregnant. However, some schools do offer counselling programmes before re-entry.

Considerations for developing the national EUP campaign

- It was suggested that revitalizing and modernizing traditional structures, such as liguma (traditional verandah) for young girls and esangweni (kraal entrances) for boys, through which Swazi elders used to groom young people, should be considered. One principal proposed that the current LSE subject for secondary schools is structured in age levels borrowing on traditional age requirement grouping, as the LSE has age appropriate and cultural sensitive content that is aligned with this.
- Rejuvenate the traditional way of raising a child by strengthening traditional family and community structures.
- The campaign should strengthen programmes that focus on prevention of EUP.
- Practical guidelines on management of pregnancy as well as re-integration into and continuation of school are needed to aid the implementation of the policy. A re-integration programme for returning teen parents should also be developed.
- The EDSEC policy and supporting guidelines should be popularized.
- Support from professionals, such as counsellors and psychologists, is needed to strengthen the response to EUP in the school system.
- Broadcasting SRH messages through popular media channels such as radio and TV should be capitalized.
- The capacity of parents/guardians, pastors, teachers, traditional leaders, community volunteers, and all other adults and elders in all sectors of society needs to be built to empower them to play a role in improving adolescent SRH, and develop tools, information, platforms and fora to achieve this.
- Mapping out partners in school, clinics and communities can strengthen and harmonize collaboration on EUP programmes.
- Community gatekeepers, such as traditional leaders (chiefs), should be involved to protect orphans and vulnerable children (OVC) in their communities from sexual abuse.
- Follow-up national dialogues targeting all sectors should be considered, and should also include feedback sessions.
- An intensive situational analysis, including the status of LSE in Swazi schools, should be conducted to establish the real picture of the magnitude of EUP and related practices, using scientifically proven methodologies.
- User-friendly tools should be developed to gather information from young people.
- EUP should be integrated as a subject in the comprehensive package on Life Skills.
- Male involvement in EUP programmes needs to be strengthened. As one participant said, “It takes two to make a baby. Let us not address girls only.”
Tanzania

Magnitude and determinants of EUP

Reports from Prime Minister’s office indicate that, even though the extent of EUPs in Tanzania is not well documented, the problem is prevalent, especially in the southern regions of the country. This is confirmed by the 2010 Tanzania DHS, which reported that 23% of young women aged 15-19 have started childbearing, and the 2015-2016 DHS and Malaria Indicator Survey (MIS), which revealed an increase in childbearing rates, with Katavi and Tabora regions reporting the most cases. The status of the EUP in Tanzanian schools is not well documented either, as the MoE does not systematically collect data on EUPs in schools. Some of the factors that exacerbate the prevalence of EUP in Tanzania include:

- Lack of empowerment for girls to negotiate safer sex;
- Low levels of SRH education and knowledge (especially in the southern regions);
- Lack of parent-child communication on SRH;
- Low uptake of SRH services by young people, partly because of the imbalance in demand and supply sides i.e. young people (demand side) are not aware of the SRH services and are therefore not able to access the services (supply side);
- Health services are not youth-friendly.

Consequences of EUP

Some of the consequences of EUP mentioned by stakeholders included contracting STIs, including HIV, and experiencing pregnancy-related complications, expulsion from school and home, early and unwanted marriages, unsafe abortions, rejection, and low self-esteem. Stigma and discrimination against pregnant and childbearing girls. There are negative perceptions and attitudes towards young girls who fall pregnant in Tanzania. They are generally perceived to be ill-behaved, and their parents are seen to have failed to raise their children correctly. It was noted that there are high levels of secrecy in the family when a girl falls pregnant, due to stigma. In some communities, however, EUPs are condoned because pregnancy proves femininity and womanhood/manhood.

National response to EUP

Education sector response

Education and Training Policy (2014)

The Education and Training Policy (2014) recognizes the right to education for all children, and free and fair education provision. Through the policy, the government commits to continue to increase potential opportunities towards education and training equally to all social groups in all spheres, including children with special needs, and to ensure that every student completes all school levels with assistance from the stakeholders.

MoEST guidelines

In contrast the Education and Training Policy, the MoEST guidelines state every pregnant female in school should immediately discontinue with their studies, as attested to by one teacher from a secondary school present at the national dialogue, who indicated that five students in her school were pregnant, and were promptly expelled in 2017. On the other hand, boys who impregnate girls tend to continue with school because many girls fear reporting who impregnated them since there are heavy penalties.
There are a number of EUP programmes in Tanzania, implemented by the government and civil societies. They are summarized below:

### Programmatic response

**Considerations for developing the national EUP campaign**

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Specific recommendations</th>
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</table>
| **CSE and SRH education** | • Provide CSE in schools (including education and provision of contraceptives e.g. condoms)  
• Encourage school children to access SRH services (promote healthy lifestyles and health-seeking behaviour)  
• Ensure that young people understand the importance of sexuality education first, before rolling out sexuality education  
• Engage parents in provision of SRH education; they should be trained on proper approaches to effectively communicate SRH issues with their children  
• Government ministries (social units - families) should provide proper guidance on sexuality communication |
| **SRH services**         | • Shift condom distribution strategies from hospitals to communities for easy access  
• SRH counselling for young people should employ an interactive (two-way communication) approach, and follow-ups should be conducted  
• Improve SRH services on both demand and supply side, by generating demand from youth and strengthening youth-friendly services  
• Strengthen the referral system i.e. use community health workers to link young people to services, or have peers to link other peers to services |
| **Collaboration**        | • Use a model that emphasizes collaboration and networking among stakeholders  
• Strengthen linkages between ministries for effective policy and guideline development and implementation |
| **Advocacy**            | • Generate high-level government support for EUP – push the EUP agenda as a priority for the government  
• Advocate for CSE to be incorporated in schools at all levels  
• Advocate for a referral system through which schools will give education and link students to health care centres for services |
| **Menstrual Health Management** | • There should be changing rooms at schools for girls to be able to conceal themselves during their menstrual period to avoid stigmatization and a wastage of time that is spent at home until the period is over  
• Employ people who can provide MHM services at schools i.e. providing sanitary pads |
| **Programmatic recommendations** | • Involve community gatekeepers to establish by-laws to support provision of SRH education and services, create social support systems, and reduce stigma at community level. District and ward level leaders and traditional/religious leaders can play an important role  
• School programmes should target both girls and young women and teachers. Girls need to know the consequences of their actions, and teachers should be reminded to uphold their code of conduct and never get sexually involved with their learners  
• Employ a multisectoral approach involving all sectors (government, communities, CSOs)  
• Peer education needs to be provided at all levels (in and outside the classroom).  
• Aim at increasing community awareness on adolescent SRH to open dialogue and reduce stigma  
• Youth/girls clubs are a good approach for SRH education  
• Focus on providing livelihood programmes to empower girls  
• Focus on shifting harmful cultural beliefs and practices  
• Interventions should emphasize empowerment, productivity, and safety for young people to optimize their health and quality of life  
• Ensure meaningful engagement of youth. We should not plan for them but plan with them.  
• Use SBCC approaches, such as outreach activities, edutainment e.g Bonanza’s, using champions as role models, and social media campaigns |
Magnitude and determinants of EUP

According to the 2016 Department of Health statistics, Uganda has high rates of teenage pregnancy. It is estimated that 24.8% of young women aged 15-19 years have given birth or are pregnant with their first child. The proportion of unplanned pregnancies among this age group is reported to stand at 41.7%. The drivers of teenage pregnancy include the socio-economic situation, lack of parental and school guidance, men’s abuse of their power, and lack of life skills on the part of the girls (UNICEF Uganda, 2014).

A needs assessment conducted to inform the development of a community-based empowerment programme found that out-of-wedlock teenage pregnancy, stigma against unmarried mothers, and lack of awareness of its magnitude and consequences were a major problem in the communities in the Manafwa district (Leerlooijer et al., 2013).

Consequences of EUP

A qualitative evaluation of a community-based empowerment programme (The Teenage Mothers Project) suggests that in addition to coping with motherhood, teenage mothers are faced with social challenges such as stigma in their communities as well as in school. Influenced by deeply embedded cultural and religious moral beliefs that disapprove of out-of-wedlock pregnancy and sex, parents, teachers, community members, fellow scholars, and community leaders generally display negative attitudes towards unmarried teenage mothers. They are perpetually subjected to shame for being unmarried teenage mothers (Leerlooijer et al., 2013). This was confirmed by qualitative interviews with stakeholders and girls in Kampala urban and semi-urban areas. Girl learners who have fallen pregnant are called different names in schools and communities such as ‘oqegere’ ('second hand') and ‘chibafu’ ('used by many men').

"Now for me (when a girl falls pregnant), society sees you badly if you get pregnant before age, you feel out of place, lose confidence, feel you have to hide or go to the village and not want to stay in that area anymore." – Urban out-of-school girls' FGD, Uganda, December 2017

"... because at school they will have expelled you (when you are pregnant)... (when you go back after giving birth)... they look at you like a bad influence, saying that how can you get pregnant in our school, and you are back again? And you are shaming the school." – Urban out-of-school female youth FGD, Uganda, December 2017

Teenage mothers also tend to have low self-confidence due to a denial of responsibility by the fathers of their child, and lack of psycho-socio support from their parents and communities during pregnancy and early motherhood. There is also a burden of material support to take care of the child by the parents or guardians of the teenager who has given birth.

Parents contribute to teenage mothers’ well-being by not expelling them from their home, allowing them to delay their marriage, giving emotional support and forgiveness, and providing teenagers support in motherhood, income generation and continued education.
Additional challenges for teenage mothers include dropping out of school because of lack of school fees and livelihood insecurity because of lack of employment after completing education (Leerlooijer et al., 2013). Qualitative interviews with young mothers’ groups showed that some young mothers preferred vocational training to returning back to school; they indicated that vocational training would help them learn skills that can earn them a living and enable them to take care of their children.

“You may want to go back to school but you have a lot of responsibilities (when you have a child). (I need) something I can do to get money. If we can get vocational education like tailoring or hair dressing…” – Young mothers’ FGD, Uganda, December 2017

Coping strategies and determinants for continued education among teen mothers

The evaluation of the Teenage Mothers Project provides evidence that individual counselling and participation in teenage mothers’ support groups, as well as having a more supportive environment, provide emotional support and help to improve low self-esteem. Some teenage mothers – especially those who were financially constrained or not financially supported by parents – found it difficult to cope with pregnancy and motherhood, and resorted to early marriage and transactional sex as a way of sustaining them and their child (Leerlooijer et al., 2013).

Continued education of unmarried teenage mothers depends on the motivation to attend school, a supportive school environment, parental support, and resources to pay school fees. Parental support seems to be the most important factor, which determines teenage mothers’ continuation with education. Their support includes financial support (school fees, school uniforms, school lunches, stationary) and childcare support when their daughter attends school. Parents who did not support their daughter’s education either did not perceive this as a priority or lacked sufficient financial resources. In some cases, in the context of limited resources, parents give priority to supporting the education of the siblings of the young mothers as the young mother is considered to have spoiled her chances by getting pregnant. Some parents are inclined to choose marriage for their teenage daughter and receive bride price, rather than providing support for education. This is partly influenced by community norms. Some teenage mothers, however, were motivated to continue their education. This was determined by:

- The goal to take good care of the child;
- Being encouraged by other teenage mothers who had succeeded in school;
- Their level of self-confidence and self-efficacy;
- Their increased awareness of the value of education because of the experience of being expelled from school.

Stigma from peers in schools was one of the key factors hampering teenage mothers’ motivation to return to school. A supportive school environment in terms of, among other things, reduced stigma and increased material and financial support, therefore contributes to continued education of many teenage mothers. Awareness-raising and persuasion by school administrators has changed their attitudes and allowed unmarried teenage mothers to return to school. Teenage mothers who return to school experienced its positive effects, such as increased autonomy, self-confidence, and income generation.

National response to EUP

Policy and legal response

Uganda has many policies and guidelines related to EUPs, such as the Guidelines for Prevention, Management of HIV/AIDS and Teenage/Unintended Pregnancy in School Setting of Uganda (2015) and the Gender in Education Sector Policy (2015). The Guidelines, for instance, have provisions for re-integration of young mothers into school, sex education/Life Skills at secondary school, creating campaigns and mechanisms for abstinence, and creating opportunities to understand and make safer sex negotiations, including condom use. Implementation of these guidelines and policies, however, remain a challenge. Further, Uganda does not have a standalone re-entry policy. As a result of weaknesses in implementation of existing policies and guidelines and a lack of a re-entry policy, cases of learner pregnancy are often dealt with at the discretion of head teachers, without strict public oversight. This means that learners who fall pregnant can be expelled, suspended, or re-admitted after delivery – with the majority being expelled (UNICEF Uganda, 2014).

The government of Uganda recently suspended all CSE activities pending the development of a national strategy.

Programme response

Most programming by government, development partners, civil society, and other stakeholders that aim to address child marriage in Uganda have focused on the drivers of the practice. These range from acute household poverty, negative social cultural and religious beliefs, weak mediating institutions, and the lack of voice and agency experienced by girls (Uganda Government/UNICEF, 2015). Some of the programmes include:

- The Teenage Mothers Project in Eastern Uganda that empowers unmarried teenage mothers to cope with the consequences of early pregnancy and motherhood;
- Government encouraging school clubs that are pathways to child participation;
- Government creation of a Gender Unit within the Ministry of Education.

Stakeholder recommendations

To address EUP in Uganda, stakeholders recommended:

- Formulating and implementing policies and guidelines on school re-entry for learners who fall pregnant;
- Implementing advocacy and social change programmes to change people’s mindset at all levels of the society;
- Strict enforcement of the law that criminalizes sex with children under the age of 18;
- Engaging cultural leaders to change cultural practices that promote EUPs;
- Promotion of positive parenting;
- Promotion of gender equality content and pedagogy in schools;
- Placement of nurses in schools to help address SRH problems among students.
High prevalence of child marriage and teenage pregnancy contribute to high fertility and population growth. Some 28.5% of girls aged 15-19 have ever been pregnant or had a live birth, with 46% of pregnancies in this age group unintended. The Ministry of General Education (MoGE) recorded 15,446 teenage pregnancies among girls in Zambian schools in 2016. In the same period, there were about 7,653 admissions back into schools.

An analysis of re-admissions in 2016 gives an average of 46% re-admission at primary level; an improvement from 38% in 2015, while at secondary level the re-admission still remains at 65%. This implies that the re-admission policy is much more effective at secondary than primary level, and that girls who become pregnant at primary school level have a higher risk of dropping out of school forever (MoGE Statistical Bulletin 2016). In terms of provincial distributions, Eastern, Southern and North Western provinces top the numbers of pregnancies at primary grades. For secondary grade pregnancies, Copperbelt leads, followed by North Western and Lusaka provinces.

In terms of re-admissions after giving birth, Northern Province had the highest rate at 58% for primary, followed by Western at 56% and North Western at 55%. At secondary level, Southern had 75% re-admission, followed by Central at 73% and Copperbelt at 69%. Rural schools have more pregnancies than urban both at primary and secondary level (MoGE Statistical Bulletin 2016). Likewise, the rates of adolescent pregnancy are higher in rural areas generally, where 37% report ever being pregnant or having a live birth, compared with 20% in urban areas. Between 2007 and 2014, a total of 120,024 in-school girls became pregnant and dropped out of school. According to the Ministry of Education, Science, Vocational Training and Early Education (MESVTEE) (2015), most of the girls (103,621) were in primary school when they became pregnant, as compared with 16,403 who were in secondary school (World Bank, 2015).

As with the other countries in the region, poverty is associated with teenage pregnancy; 45% of adolescents aged 15-19 in the lowest wealth quintiles reported having ever been pregnant, compared with 10% in the highest wealth quintile. This suggests that being poor and living in rural areas predisposes adolescents to early pregnancy. In addition, since adolescent girls in Zambia suffer from under-nutrition, they are at higher risk for complications during pregnancy and childbirth. Their children are also more likely to have high mortality and morbidity, poor nutritional outcomes, and lower development and school readiness by the age of six (World Bank, 2015).

**Stigma and discrimination against pregnant and childbearing girls**

In Zambian communities, EUP-related stigma is higher for girls than for boys as a result of cultural beliefs and practices that reinforce and influence gender imbalances. Early pregnancy is shameful, especially for the parents. In some communities (especially in rural communities), however, childbearing adolescents are welcome as they bring in income for the family when married off. In such instances, SRH programmes that aim to prevent EUPs are not welcome as they are seen to be obstructing the financial and material gains that EUP brings to families.
Linkages between schools and health services

Existing SRH services in schools
Schools provide SRH information to students through CSE and counselling, which in turn generates demand among boys and girls who then access health services in clinics. This is inclusive of counselling. Stakeholders highlighted the need to marry information with access to services, and recommended the use of peer educators in schools to promote ASRH. SAF AIDS has such a peer programme (Young 4 Real Club), where young people are given toolkits and referral slips for their members to go and access services.

Existing referral system
The MoGE mandate does not allow delivery of SRH services on the school premises because this responsibility lies with the MoH. As such, the MoGE provides students with information about where students can go to find the SRH services. PPAZ has a Join-in Circuit programme of providing linkages between learners and health services directly through after-school programmes.

National response to EUP

Policy response
The following are some of the policies, guidelines, and frameworks that address EUP in Zambia:

- Re-entry Policy (MoGE);
- Life Skills-based CSE framework (MoGE), which contains comprehensive SRH information for adolescents and young people in schools;
- The out-of-school CSE curriculum (Ministry of Youth and Sport) which is aimed at providing SRH information to young people out of school;
- Policy on HIV and Wellness (MoGE), which contains information on preventive measures that adolescents and young people in schools could take to prevent themselves from pregnancy, HIV and STIs;
- The Adolescent Health Strategy (2017-2021), which guides the provision of HIV and SRH-related information and services and strengthens the “youth-friendliness” of existing services, with a particular focus on reducing stigma and discrimination faced by young people and improving SRH service provider attitudes;
- The National AIDS Strategic Framework (2017-2021) to support and provide adolescents and young people with adequate access to inclusive and responsive HIV and SRH services;
- MoGE, MoE, and other stakeholders have developed strategies that are currently being used in Zambian schools for adolescent programmes, such as youth clubs.

Programmatic response
CSOs that implement EUP programmes in Zambia include FHI 360, Zambia Centre for Communications Programmes (ZCCP)-Kwatu, Restless Development, Southern Africa HIV and AIDS Information Dissemination Service (SAF AIDS), Marie Stopes, Young Women’s Christian Association (YWCA), Planned Parenthood Association of Zambia (PPAZ), Centre for Reproductive Health and Education (CRHE), Forum for African Women Educationalist in Zambia (FAWZ), Southern African AIDS Trust (SAT) Zambia, Oxfam, Pact Zambia, USAID and Churches Health Association of Zambia (CHAZ). UN agencies supporting EUP programmes include UNESCO, UNFPA, and UNICEF.

Programmes implemented include:

- CSE and SRH education;
- Youth empowerment;
- Capacity-building for young people (in and out of school) as well teachers;
- Youth peer programmes and youth clubs;
- Radio listener clubs;
- Community dialogues with teachers, pupils and community members;
- Teacher mentorship, guidance and counselling programme;
- School feeding programmes;
- Scholarship programmes for young mothers;
- Community mobilization;
- Internet-based youth hubs for social interaction;
- Stop Child Marriage and safe spaces programmes that provide social and economic support to school going children;
- Mobile health (phone and sms) programmes.

Another government arm that invests in EUP apart from the MoH and MoGE is the Ministry of Chiefs and Traditional Affairs (MoCTA), which has been implementing programmes for traditional leaders against harmful cultural practices, such as teaching young girls how to entertain men in bed. In addition, the Ministry of Youth and Sport implements programmes on EUP for out-of-school youth.

Education sector response

CSE
CSE is integrated into different subjects of the curriculum (three subjects in primary school and four subjects in secondary school), with the aim of providing age-appropriate information on sexuality education in Zambian schools. Conceptually, CSE was meant to be taught from Grade 1, but national stakeholders felt that CSE should instead be taught from Grade 5. Nevertheless, information on sexuality is still provided to learners in lower grades, for example, younger learners are taught about ‘bad touch’ and ‘good touch.’ There are prospects for CSE to be taught in the lower grades as well. Clubs are used in certain schools to discuss SRHR issues. Rural areas are more apprehensive towards CSE because it clashes with traditional teachings and practices.

The MoGE has developed the Adolescent Sexual and Reproductive Health and Rights Package which is used to teach CSE in schools. Although one of the key challenges in delivering CSE in schools is the lack of a CSE teaching and learning materials, UNESCO has supported the MoGE to develop CSE learner and teacher books for Grades 5, 6, 8, 9, 10 and 11. The books will be distributed to schools in the first quarter of 2018. Schools in Zambia have also introduced enhanced psycho-social support where all teachers provide counselling. Pupils are encouraged to talk to the guidance counsellors about their issues.
Re-entry Policy

There is a re-entry policy in Zambia, which ensures that pregnant learners are re-admitted into school. Parents are given the option of transferring their daughters to another school to mitigate bullying and stigma. The MoGE also makes provision for a co-parent to be assigned to the family of the boy and girl learner for counselling and advice regarding EUP, to help them to handle the situation. The re-entry policy can only be used twice, after which the pupil is not allowed to re-enter the school system. While the policy has helped many learners to complete their education, some parents and teachers feel that the policy breeds indiscipline because some re-entered learners become ungovernable. Apparently, some parents have little knowledge on the policy and how it works. According to the re-entry policy, male learners who impregnate fellow learners are put on leave from school for a shorter period than the girls as a penalty. The Education Act declares that any person who impregnates a learner (regardless of the learner’s age) commits a felony. It is noted that mission schools do not re-admit pregnant into school under any circumstance as they believe this practice motivates the learners to not engage in risky sexual activities.

Considerations for developing the national EUP campaign

Stakeholders provided the following recommendations for developing a national EUP campaign in Zambia:

• The campaign should be tailor-designed and packaged for different target audiences at different levels.
• Put more emphasis on behaviour change communication, and develop relevant communication materials. “Adverts and media information should be everywhere.”
• Build the capacity of implementing partners to be able to deliver the campaign effectively, and focus on changing service providers’ attitudes to optimize uptake of adolescent SRH services.
• Employ a multi-dimensional approach that includes all stakeholders and leaders of various sectors to raise awareness of EUP issues at the community level.
• Focus on changing people’s mindsets and attitudes, especially in rural communities, by conducting sensitization campaigns on EUP effects.
• It is important to extensively explore the underlying factors for risky sexual behaviours among young people, and address them through the campaign.
• Primarily target girls with life skills and empowerment interventions because they are the ones who carry the pregnancy. Target younger girls in primary schools as well, because they are most vulnerable in their homes i.e. issues of rape and incest.
• Target the following secondary target audiences:
  - Young boys (so that they are aware of the consequences of unprotected sex);
  - Teachers, parents/guardians and other such audiences that directly influence young people’s lives and behaviours;
  - It has been noticed that traditional norms and statutory laws conflict. Therefore, work using a strategy with traditional leaders on how to prevent teen pregnancy with the help of MoCTA is underway;
  - Communities (to shift mindsets that are deeply rooted in harmful cultures);
  - FBOs (to reach young people who attend and participate in church activities);
  - Traditional chiefs (to facilitate by-laws that counter risky actions and behaviours that may aggravate EUP at the community level);
  - HCWs to optimize YFHS.
Situational analysis on early and unintended pregnancy in Eastern and Southern Africa

Magnitude and determinants of EUP

The Zimbabwe National Adolescent Fertility Study (2016) reports a pregnancy rate of 9% among adolescents aged 10-19 years, with the older (15-19) age group reporting more pregnancies (17%) compared to the younger (10-14) age group, at 0.2%. One in ten adolescent girls give birth every year. Rural girls (10-19) are more at risk of EUP than their urban counterparts, at 21% and 7% respectively. Pregnancy rates appear to increase with age among young people; the Zimbabwe DHS reported the following teenage pregnancy rates: 1.8% for 15-year-olds, 6.7% for 16-year-olds, 15.7% for 17-year-olds, 22.9% for 18-year-olds, and 40.9% for 19-year-olds. The prevalence of adolescent pregnancy is reportedly highest in Mashonaland Central (due to religious marriage practices and artisanal gold mining) and lowest in Harare. EUP is also reportedly higher in mining areas, growth points and border posts.

Stigma and discrimination against pregnant and childbearing girls

Pregnant girls are often considered a bad influence (“rotten tomatoes”) to other girls in their communities. They are perceived as promiscuous and deviant; are victimized, shunned, and derogatively labelled as “mvana” (a young person having a child out of wedlock) or “nzenza” (a good-for-nothing/useless person). However, some families, especially those with strong religious beliefs, view pregnant girls as a financial solution to alleviate poverty, especially if they get married (bride price paid).

In schools, pregnant girls have the option of getting emotional support from the Guidance and Counselling teachers, but the majority prefer not to go for counselling due to low self-esteem and fear of being chastised and ridiculed by both students and teachers.

Sources of SRH information for young people

Young people in Zimbabwe get SRH information through mass media, especially radio. Other avenues include IEC materials such as pamphlets and flyers; teachers in schools; the internet and social media, especially for urban youth; and friends and peers, especially in rural areas where there is less reliance social media and TV.

Linkages between schools and health services

Zimbabwe provides AYFHS in accordance with the National Guidelines on Clinical Youth-Friendly SRH Service Provision that were developed using WHO standards for quality health care services for adolescent and youth interventions. These services are, however, not available in primary and secondary schools and thus, health-related services offered in most primary and secondary schools are limited to information provision through peer education within health clubs, SRHR education through sport, as well as teacher-led Guidance and Counselling LSE. Adolescents and youth in primary and secondary schools are referred to public health institutions and known ASRHR-implementing CSOs in the community for all health services.
National response to EUP

Policy response
Existing policies, strategies and laws that address EUP include:

• The Zimbabwe National Adolescent and Youth Sexual and Reproductive Strategy (2016-2020)
• The Child Marriages Act
• Section 78(1) of the Constitution of the Republic of Zimbabwe Amendment Number 20 of 2013
• Section 22(1) of the Marriage Act (Chapter 5:11)
• The National Gender Policy (2017)
• The National Action Plans for OVC

NOTE: Abortion is illegal in Zimbabwe, unless approved by a doctor on medical grounds.

Programmatic response
EUP programmes in Zimbabwe are implemented by government departments, as well as CSOs. Some of these programmes include:

• Youth-friendly SRH services;
• The Young People’s Network on Sexual and Reproductive Health and HIV/AIDS (supported by the National AIDS Council in collaboration with the National Adolescent Sexual and Reproductive Health Coordination Forum. It is an advocacy network of 12 youth serving organizations);
• Behaviour Change Communication, spearheaded by Padare, SayWhat, SAFAIDS and Restless Development;
• Ending child marriage campaigns (The 18+ campaign by Plan Zimbabwe, ”Give us books, not husbands” campaign by Katswe Sistahood, ”Not Ripe for Marriage” campaign by Real Opportunities for Transformation, and other such campaigns by ROOTS and SAFAIDS);
• Community mobilization and leadership engagement;
• Community dialogues spearheaded by SAFAIDS;
• Sister-Sister clubs;
• School-based empowerment movement clubs and gender transformative programmes;
• Global and national awareness days (16 Days of Activism Against Gender-based Violence, International Women’s Day, World AIDS Day).

Education sector response to EUP

CSE
The Education Sector Strategic Plan (2016-2020) guides the implementation of CSE in Zimbabwe. It is included in the Life Skills and Guidance and Counselling syllabus in secondary schools. Learning materials have also been revised or developed in line with the new curriculum. There is also a revised curriculum and teachers’ manual. Training of teachers and heads of schools on CSE is ongoing. However, neither are all students taught CSE interventions, nor is the subject always given priority by the responsible teachers. Additional ASRH information is provided in schools through the school health/HIV and AIDS clubs, peer education, peer-to-peer debates, drama, and parent to child communication. The DREAMS programme is implementing CSE interventions in a limited number of districts through FHI 360. The Ministry of Primary and Secondary Education issued a circular on the “Implementation Guidelines for the Institutionalization of the Guidance and Counselling Programme in all Primary and Secondary Schools” which guides implementation of CSE in the country (Directorate circular Number 23 of 2005). This initiated Guidance and Counselling classes for girls and boys in all schools. ASRH is, however, a small component of the Guidance and Counselling syllabus.

Re-entry Policy
The Ministry of Primary and Secondary Education issued a policy circular (Discipline in Schools: Suspension, Exclusion, and Corporal Punishment) that addresses EUP and re-entry into school for girls who leave due to pregnancy. This circular states that pregnant learners are allowed to take leave from school, and that if the young mother (former pupil) wishes to go back to school, or her parents/guardians wish for their daughter to do so, the head of the school at which the pupil was before giving birth shall do everything possible to facilitate her re-enrolment in the same grade/form in which she was before leaving. Communities are, however, not fully aware of this policy circular and school heads are not keen to implement and sensitize learners and communities on the policy.

Considerations for developing the national EUP campaign

• Invest in systematic research and M&E of school health programmes to optimize school-based SRH programmes.
• Provide education on contraceptives and condom use in schools to promote access and uptake by sexually active adolescents and youth.
• Strengthen laws and frameworks for older men who impregnate young girls.
• Strengthen multisectoral collaboration and partnerships across government sectors and line ministries, as well as other key players in EUP In addition, improve private-public partnerships and strengthen the linkage between the MoH and MoE.
• Emphasize youth engagement and participation – interventions and messages should be led by young people.
• Scale-up youth-friendly ASRH services so that young people can access quality and acceptable care.
• Widely disseminate the Re-entry Policy to parents and communities at large to increase awareness and facilitate implementation.
• Alignment of laws such as those on the age of consent and legal age of majority act is required so that sexually active adolescents can access contraceptives. While the Zimbabwe Family Planning Guidelines stipulate that access to contraceptives should be allowed to all sexually active people irrespective of age, its implementation has been largely arbitrary.
• There is a need for sufficient funding and resourcing of the ASRH programme in general, but more so in schools. Funding could be increased and sustained through strengthening of domestic funding for CSE.
• Consider using SBCC strategies and approaches to address EUP. Specific activities could include talk shows, drama and theatre, and school competitions.
• Involving role models and popular figures (champions) in the campaign could yield success.
• Leverage ICT to promote youth-friendly approaches and methodologies for developing the campaign and related messages.
• Prioritize strengthening parent-child communication on SRH.
• The campaign should target all segments of communities and society, including hard-to-reach, conservative, and closed communities. Communities should be involved at every level of the planning and implementation process.
• Deliberately target EUP interventions in rural areas where EUP is widespread.
• Ensure a robust budget to systematically plan and implement the EUP campaign over a long period of time to optimize reach and impact.
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Situational analysis on early and unintended pregnancy in Eastern and Southern Africa
Appendices

Appendix I: Interview guides, information sheet and consent forms

INTERVIEW GUIDES

Guide for interviews with government officials

Appropriate introduction – refer to information sheet and consent forms.

1. What is the situation regarding early and unintended pregnancies (EUP) in this country?
2. How has government responded to this situation?
   a. What policies are in place to prevent EUPs?
   b. What policies are in place to help learners who fall pregnant?
   c. How have these policies worked?
   d. What are the policy gaps?
   e. What challenges do you face in implementing these policies?
   f. What laws are in place to enable these policies?
      i. What legal recourse do girl learners who fall pregnant have?
   g. What programmes are in place to address EUPs?
   h. How effective have these programmes been?
3. How has the school curriculum responded to the problem of EUP?
   a. What topics are covered in the curriculum?
   b. What challenges do you face delivering the curriculum on sexuality education?
   c. What other topics do you wish to cover but are not covered? Why are those topics not covered?
4. What are the barriers to teenage mothers completing their education?
   a. How can these be overcome?
5. How can teenage mothers who return to school be supported?
6. What measures are put in place to make sure that adolescents in schools have access to sexual and reproductive health (SRH) services?
   a. How do adolescents in schools access SRH services?
   b. What challenges do they face in accessing SRH services?
7. What challenges do pregnant and childbearing girls in schools face?
8. What challenges do pregnant and childbearing girls in communities face?
   a. What is government doing to eliminate stigma and discrimination toward pregnant and childbearing girls in schools and communities?
9. What do you suggest to be done to address EUP in your country?

GUIDE FOR INTERVIEWS WITH CSO REPRESENTATIVES

Appropriate introduction – refer to information sheet and consent forms.

1. What is the situation regarding early and unintended pregnancies (EUP) in this country?
2. How has government responded to this situation?
   a. Which sectors have responded to EUP? How?
   b. What policies are in place to prevent EUPs?
   c. What policies are in place to help learners who fall pregnant?
   d. How have these policies worked?
   e. What are the policy gaps?
   f. What challenges do you face in helping to implement these policies?
   g. What laws are in place to enable these policies?
      i. What legal recourse do girl learners who fall pregnant have?
3. How have CSOs responded to this situation?
   a. What programmes are in place to address EUPs?
   b. How effective have these programmes been?
4. How has the school curriculum responded to the problem of EUP?
   a. What topics are covered in the curriculum?
   b. What challenges do schools face in delivering the curriculum on sexuality education?
   c. What other relevant topics would you recommend to be covered but are not covered? Why are those topics not covered?
5. What happens to girl learners who fall pregnant?
   a. What challenges do you face trying to keep girls who fall pregnant in school?
   b. What support do they get during pregnancy? After child birth?

6. How do adolescents in schools access sexual and reproductive health (SRH) services?
   a. What challenges do they face in accessing SRH services?
   b. What measures are put in place to make sure that adolescents in schools have access to SRH services?

7. What challenges do pregnant and childbearing girls in schools face?

8. What challenges do pregnant and childbearing girls in communities face?
   a. How are they perceived by the community? (probe stigma and discrimination)
   b. How are they treated by the community? (probe stigma and discrimination)
   c. What measures (if any) are taken to eliminate stigma and discrimination towards pregnant and childbearing girls in schools and communities?

9. What do you suggest be done to address EUP in your country?

GUIDE FOR INTERVIEWS WITH (HEAD) TEACHER

Appropriate introduction – refer to information sheet and consent forms.

1. What is the situation regarding early and unintended pregnancies (EUP) in this country?

2. How have schools responded to EUPs?
   a. What happens to girl learners who fall pregnant?
      i. What challenges do they face?
      ii. Is there a chance of them continuing with school? Explain
      iii. Is there a chance for them going back to school after delivery? Explain
      iv. What support do they get during pregnancy? After pregnancy?
      v. Is this guided by any policy direction from government? What policy?
   b. How do schools prevent EUPs?
      i. Is this guided by any policy from government? Which policy?
   c. What challenges do you face in preventing EUPs?
   d. What challenges do you face in helping learners who fall pregnant?
   e. What challenges do you face in trying to keep girls who fall pregnant in school?
   f. What challenges do girls who fall pregnant face when returning to school?
   g. How many girls on average drop out of school due to pregnancy each year?
   h. How many girls on average are re-admitted to school after they fall pregnant? How do you capture that?
   i. How can schools support re-entry of girls after childbirth?

3. What is your view about a re-entry policy?
   a. Do you support it? Why? Why not?

4. What subjects are taught at your school that can help address EUPs?
   a. What topics do you teach in this regard?
   b. What has worked well in teaching these topics?
   c. What are the challenges in teaching these topics?
   d. What other topics do you wish to be covered but are not covered? Why are those topics not covered?
   e. What topics should be removed? Why?

5. How do adolescents in schools access sexual and reproductive health (SRH) services?
   a. What challenges do they face in accessing SRH services?
   b. What measures are put in place to make sure that adolescents in schools have access to SRH services?

6. What challenges do pregnant and childbearing girls in schools face?

7. What challenges do pregnant and childbearing girls in communities face?
   a. What do you do to eliminate stigma and discrimination towards pregnant and childbearing girls in schools and communities?

8. What do you suggest can be done to address EUP in your school?
GUIDE FOR FOCUS GROUP DISCUSSIONS WITH RURAL AND URBAN OUT-OF-SCHOOL GIRLS AGED 18+ YEARS

Appropriate introduction – refer to information sheet and consent forms.

1. What challenges do girls face in this community?
2. What do girls in this community do to prevent early and unintended pregnancies?
   a. What challenges to you face following these methods?
3. What do girls do when they fall pregnant?
   a. What challenges do they face?
4. What happens to girls who fall pregnant while at school?
   a. Are they re-admitted after giving birth?
   b. Do you know about government policy on re-entry?
5. Where do girls learn about growing up and sexuality in your community?
   a. What do you learn?
   b. How useful is it?
   c. Which sources of sexual and reproductive health (SRH) information do you trust? Why?
6. What stops girls from completing school?
   a. What led you to leave school?
7. At what age do girls often get pregnant in this community?
   a. What do you think the reasons are?
8. Where do you get services on SRH?
   a. What services do you get?
   b. How accessible are these services?
   c. What challenges do you face in accessing these services?
9. What problems do girls face when they fall pregnant in this community?
   a. How are they perceived by the community? (probe stigma and discrimination)
   b. How are they treated by the community? (probe stigma and discrimination)
   c. What problems do girl learners face when they fall pregnant?

GUIDE FOR FOCUS GROUP DISCUSSIONS WITH YOUNG MOTHERS AGED 18-25 YEARS

Appropriate introduction – refer to information sheet and consent forms.

2. What challenges do girls face in this community?
3. When you first fell pregnant, what challenges did you meet?
   a. Probe on school dropout and/or re-entry
   b. Probe reaction from parents, teachers, and community members
   c. How did you overcome these challenges?
   d. What help did you get from the community?
   e. How could schools support/help with school completion?
4. At what age do girls often get pregnant in this community?
   a. What do you think the reasons are?
5. What do girls in this community do to prevent early and unintended pregnancies?
   a. What challenges do they face following these methods?
6. Where do girls learn about growing up and sexuality in your community?
   a. What do they learn?
   b. How useful is it?
7. Where do you get services on sexual and reproductive health (SRH)?
   a. What services do you get?
   b. How accessible are these services?
   c. What challenges do you meet accessing these services?
8. What problems do girls face when they fall pregnant in this community?
   a. How are they perceived by the community? (probe stigma and discrimination)
   b. How are they treated by the community? (probe stigma and discrimination)
   c. What problems do girl learners face when they fall pregnant?
GUIDE FOR FOCUS GROUP DISCUSSIONS WITH PARENTS AGED 35+ YEARS

Appropriate introduction – refer to information sheet and consent forms.

1. What challenges do girls face in this community?
2. At what age do girls often get pregnant in this community?
   a. What do you think the reasons are?
3. What do girls in this community do to prevent early and unintended pregnancies?
   a. What challenges do girls face following these methods?
   b. What do you think of the prevention methods? Do you support them?
4. What do girls do when they fall pregnant?
   a. What challenges do they face?
   b. What support do they get?
5. Where do girls learn about growing up and sexuality in your community?
   a. What do they learn?
   b. How useful is it?
6. What happens to girl learners who fall pregnant?
   a. What challenges do they face?
   b. Is there a chance of them continuing with school? Explain
   c. Is there a chance for them going back to school after delivery? Explain
   d. What support do they get during pregnancy? After pregnancy?
7. Where do girls get services on sexual and reproductive health (SRH)?
   a. What services do they get?
   b. How accessible are these services?
   c. What challenges do they meet accessing these services?
8. What problems do girls face when they fall pregnant in this community?
   a. How are they perceived by the community? (probe stigma and discrimination)
   b. How are they treated by the community? (probe stigma and discrimination)
   c. What problems do girl learners face when they fall pregnant?
9. What do you think should be done to prevent early and unintended pregnancies in this community?

INFORMATION SHEET

Dear participant(s),

My name is ……………………… and I am conducting this study on behalf of UNESCO. The study is on early and unintended pregnancies in your area. The findings of the study will be used to inform and develop UNESCO programmes aimed at reducing early and unintended pregnancies in the country.

I have a few questions I would like to ask you. Our discussion will take about one hour.

Before we start our discussion, I would like to assure you that participation is voluntary. I would also like to assure you that your responses will be kept confidential in that it is only me and my fellow researchers who will access unprocessed information that you give me, and that your names will not be linked to your responses in the report. If in the course of our discussion you feel like discontinuing, you are free to do so.

I have with me consent forms which I will ask you to fill if you agree to participate.

If you have any questions regarding this research, you can ask me now or at the end of the interview, or contact me at the following:

Name of researcher: …………………………………………………………………………………………………………………………………………………………………………………………………………………
Cell phone: …………………………………………………………………………………………………………………………………………………………………………………………………………………
E-mail: …………………………………………………………………………………………………………………………………………………………………………………………………………………

I therefore invite you to participate in this research exercise.

Thank you.

Name of researcher: …………………………………………………………………………………………………………………………………………………………………………………………………………………
CONSENT FORMS

Interview consent form:

Date: ..............................................................

I………………………………………… consent to being interviewed by ………………………………… on early and unintended pregnancies in my area. I understand that the research is being conducted on behalf of UNESCO to help design programmes aimed at addressing early and unintended pregnancies.

I agree to the following:
• Participation is voluntary
• Participation in the interviews will require about 1 to 2 hours
• I have the right to refuse participation
• I have the right to refuse to answer any question posed during the interviews
• I can withdraw at any time in the course of the interview
• I have the right to be identified as anonymous and all responses are confidential
• I (or my organization) have the right to review any quotes from the interview that will be used in the final report.

Full name: ..................................................................................................................................................
Organization (if applicable): .................................................................................................................................
Signed: ..........................................................................................................................................................
Date: .............................................................................................................................................................

Recording consent form:

Date: .............................................................................................................................................................

I………………………………………… consent to having my interview electronically recorded by ………………………………… for the study on early and unintended pregnancies. I understand that transcripts or copies of the recording will be made available on request.

Full name: ..........................................................................................................................................................
Organization (if applicable): .................................................................................................................................
Signed: ..........................................................................................................................................................
Date: .............................................................................................................................................................
Appendix II: Discussion guide for national stakeholder dialogues

• What is the current situation regarding early and unintended pregnancies (EUP) in this country? How big is the problem?

• What is the current national programmatic and policy response to EUP?
  Probes:
  - What is currently happening? What policies or strategies are in place to address EUP?
  - Which institutions are implementing programmes on adolescent sexual health, particularly addressing EUP?
  - What specific interventions and approaches are being used? (Probe for the following approaches: social and behaviour change communication, community mobilization, advocacy)
  - Is there a nationwide campaign on EUP? Explain
  - Are there any advocacy networks focusing on adolescent sexual and reproductive health (SRH), specifically EUP?

• What is the education sector doing to address EUP in the country?
  Probes:
  - What is the Ministry/Department of Education doing to address EUP?
  - Is comprehensive sexuality education (CSE) included in the primary school curriculum? Is it being taught in schools? How comprehensive is the CSE?
  - What are the different approaches used to teach sexuality in schools?
  - Where do young people get SRH information from? Which source do young people trust most?

• What happens to pregnant and childbearing adolescent girls who are in school?
  Probes:
  - Does the country have re-entry policies? How is it being implemented? Are teachers, parents, and children aware of the policy?
  - What happens to girls who fall pregnant in school? What about boys who impregnate the girls? (Probe: Is there a standardized practice across the country, or are there variations in schools?)
  - Is there any legislation for getting young mothers back in school? Explain
  - How are pregnant girls and young mothers being supported in schools? Who supports them?

• What health services are available to young people in school?
  Probes:
  - Are SRH services available to children in schools? Why/why not?
  - Are there any linkages between schools and SRH services? Does the school refer children to SRH services?

• How do various communities perceive pregnant and childbearing adolescents?
  Probes:
  - What do people think of them? How are they treated in communities? How do community members react to such a situation?
  - How are pregnant adolescents and adolescent others treated in schools? How do teachers react?
  - How are pregnant adolescents and adolescent others treated at home? How do parents react?
  - What words do community members use when they refer to pregnant adolescents or adolescent mothers?
  - What about adolescent fathers? How are they treated/perceived?

• What can we do to improve the programmatic response to EUP in this country?
  Probes:
  - Where are the gaps in EUP implementation?
  - If we were to develop a campaign addressing EUP in this country, what would you consider helpful? (probe for key factors/determinants to be addressed, approaches to use, target audiences, appropriate communication channels to utilize)
UNESCO is the United Nations’ specialized agency for education. It provides global and regional leadership in education, strengthens national education systems, and responds to contemporary global challenges through education, with a special focus on gender equality and Africa.

UNESCO’s mission on the area of health education
- Promoting healthy lifestyles among girls, boys, young women, and men through skills-based education in formal educational settings, non-formal educational activities, and informal education.
- Ensuring that all children benefit from good quality comprehensive sexuality education that includes information on HIV prevention.
- Ensuring that all children and young people have access to safe, inclusive, health-promoting learning environments.

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