IMPROVING ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRH) FOR SUSTAINABLE REDUCTIONS IN PERSISTENT ACUTE MALNUTRITION IN SAMBURU AND TURKANA

LEARNING BRIEF

INTRODUCTION & RATIONALE

In Samburu and Turkana counties, where more than 25% and 20% of adolescents, respectively, have begun childbearing, adolescent pregnancy poses a major impediment to the sustainable reduction of persistent global acute malnutrition (P-GAM) and the counties' socio-economic development more broadly. Pregnancy during adolescence, particularly among girls who have been malnourished from before birth, not only increases the immediate risk of maternal and infant morbidity and mortality, but compromises healthy, empowered transitions to adulthood. Furthermore, early childbearing is closely

linked with higher lifetime fertility. Estimated at 6.3 and 6.9, the total fertility rate in Samburu and Turkana, respectively, places these counties well above the national rate of 3.9.[1]

During Phase 1, USAID Nawiri embarked on a learning journey to uncover the nuanced and complex realities of the individual, interpersonal, community, and structural influences that shape adolescent pregnancy and childbearing in Samburu and Turkana. Analyzed through a nutrition lens, findings have helped illuminate high-potential pathways for addressing the drivers and managing the effects of early pregnancy to support the sustainable reduction in undernutrition, long after the end of USAID Nawiri. This learning brief highlights key insights from this participatory learning journey and implications for USAID Nawiri's strategic planning and programming for Phase 2, including priority topics for continued, adaptive learning within the program's larger "1,000 to 10,000 day" area of inquiry. This area of inquiry accepts that integrated, layered, and sequenced interventions that go beyond addressing children and young people's physical health and nutrition needs, and encompass the full range of socio-emotional and cognitive support they require during the first 10,000 days (24 years), will be key to interrupting intergenerational cycles of poverty and undernutrition.

LEARNING JOURNEY

In Phase 1, USAID Nawiri's learning journey was iterative and participatory, beginning with identification of evidence gaps and co-creation of a statement of work with county stakeholders. USAID Nawiri's technical working group on adolescents and youth, which includes government stakeholders from both counties, identified and synthesized peer reviewed literature, published and unpublished reports, news media, and more to understand evidence of the drivers and mitigating factors of risks and vulnerabilities that lead to pregnancy and childbirth among adolescent girls. This involved closely monitoring and interrogating sexual and reproductive health (SRH) and other trends during the COVID-19 pandemic to ensure USAID Nawiri was exploiting the opportunity afforded by this extraordinary shock to glean insights into the resilience of existing systems in relation to adolescent health. Landscape analysis and stakeholder mapping complemented the desk review and context monitoring to provide a better understanding of ongoing adolescent reproductive health efforts and potential entry points to engage adolescents in Samburu and Turkana counties.

In partnership with human-centred design (HCD) firm, ThinkPlace, USAID Nawiri facilitated its Adolescent Advisory Committee (AAC),[2] county government officials, and other stakeholders through a participatory process involving the prioritization of action-oriented learning questions, followed by insight gathering among adolescents and their parents/guardians; data synthesis and analysis; and the ideation and co-creation of solutions for testing. Grounded in the principles of HCD, this process provided a platform for interpreting and triangulating information obtained from the desk review,

[1] (2015) National Bureau of Statistics-Kenya and ICF International, 2014 KDHS "Key Findings". KNBS and ICF International, Rockville, Maryland, USA

[2] The AAC is group of 15 adolescents from Samburu and Turkana, identified by the community-based youth led or youth serving organizations to represent the diverse typologies of adolescents and young people (aged 10-24) to ensure meaningful engagement of adolescents and young people in the HCD process and subsequent adolescent and youth SRH interventions.

landscape analysis, stakeholder mapping, and context monitoring, while elevating adolescent voices in identifying solutions that will work for them. USAID Nawiri also leveraged a strategic partnership with USAID's MOMENTUM Country and Global Leadership project to facilitate a first-of-its-kind adolescent- and gender-responsive health systems assessment in both counties. Through the assessment process, USAID Nawiri gathered adolescent inputs on the responsiveness of the system, and used a participatory workshop with county health management teams to foster dialogue, debate, and consensus on the responsiveness of the health system across a range of features.

INSIGHTS AND IMPLICATIONS

INSIGHT N°1: A system of contradictions, and the shame, fear, and uncertainty it produces, restricts adolescent girls' agency over their sexual and reproductive health, and life choices in general, including their ability to take proactive steps to prevent pregnancy.

Social stigma around adolescent sexuality in Samburu and Turkana does not appear to decrease sexual activity, but rather increase risk-taking behaviors around sex and reproductive health--a finding that USAID Nawiri believes can be explained, at least in part, by a *system of contradictions* that undermine girls' agency over their own reproductive health and life choices and exposes them to a myriad of SRH risks, including early pregnancy. For example, while pregnancy outside of marriage is highly stigmatized in both counties, sex at an early age is implicitly condoned in Samburu, including through traditional practices such *beading*. Unmarried adolescent girls in Samburu and Turkana fear pregnancy and the related stigma, but also fear negotiating contraceptive use or seeking contraceptives (as a marker that they are sexually active).

> "Yes, girls fear pregnancy a lot, but they also fear what will happen if they insist that [their partner] use a condom. He can shame her by accusing her of having HIV or another infection. And that brings her mind to a place where she is imagining everyone in the community thinking she has a disease. That one makes her fear of pregnancy leave her and she just agrees not to use a condom." Adolescent girl, 17 years, Turkana

Adolescent girls who become pregnant are at high risk of pregnancy-related complications; and those that experience such complications are often ostracized by society, particularly their parents. Marriage provides parents of girl children a source of income and is seen as a prestigious way of obtaining wealth; pregnancy before marriage, therefore, is feared by parents as a threat to attaining this status. Young women complain of the contradiction created by parents who teach their daughters to fear boys as a pregnancy-prevention tactic, and a society that teaches girls that they cannot say no to sexual advances from men. Parents' fear of premarital pregnancy has been cited as among the key contemporary drivers of early marriage in both counties, and may help explain the reported increase in early marriage during the first phase of the COVID-19 pandemic.

> *"When schools closed and girls returned home, it was also the time of initiation for the moran and these warriors were very active. Parents feared their daughters would soon get pregnant and they [the parents] would lose the dowry and the investment in her education, so it was better they look for a husband and marry her quickly."* County Government Official, Samburu

Feeding this system of contradictions in Samburu and Turkana are conventional approaches to policy and programming that engage adolescents as beneficiaries, not partners, and pay insufficient attention to the socio-cultural and structural determinants of their SRH and broader health outcomes. Transforming the system of contradictions and activating synergies between improved ASRH and nutrition and will require addressing harmful social norms and cultural practices. Drawing on recent evidence and experience generated by USAID's Passages,[3] Mercy Corps' Building Resilience through the Integration of Gender and Empowerment (BRIGE) project,[4] and other tested social change approaches, USAID Nawiri will embrace social change dialogue-based techniques that engage male and female community stakeholders, adolescent girls and boys, and their families in reflection and action-oriented dialogue (ToC Reference: IO 3.1.1). In addition, USAID Nawiri will engage custodians of culture and multi-sectoral system actors to influence reshaping gender and generational norms by redefining and re-socializing *morans* and warriors as "Warriors for Health and Nutrition" (ToC Reference: IO 3.1.3)

INSIGHT N°2: The social isolation of pregnant, parenting, and/or married adolescent girls presents a key barrier to the sustainable reduction of p-gam in Samburu and Turkana.

A combination of factors perpetuates the marginalization of one of the counties' most vulnerable population groups--a group that has grown larger in number as a result of the reported increase in early marriage and teenage pregnancy triggered by the ripple effects of the COVID-19 pandemic. Stakeholders report that the fear of being accused by local communities of "promoting teen pregnancy" is among the reasons why a majority of youth-focused programs shy away from working with pregnant or parenting adolescent girls. Additionally, there is the practical challenge of identifying and locating pregnant and parenting adolescent girls, as USAID Nawiri discovered during data collection for the gender analysis. Pregnancy before marriage drives many young girls and their parents to undertake severe measures to hide or terminate the pregnancy. In Samburu, pregnant, parenting, and/or married adolescent girls are simply not a population group recognized by society; when a girl child becomes pregnant or gets married, she is a woman, regardless of her biological age. Biological age is also difficult to ascertain given poor documentation of proper birth registration in Kenya's arid and semi-arid lands.

When pregnant, unmarried adolescent girls hide in the community and do not access antenatal care services, it produces a negative cascade of compounding effects. They are at greater risk of unsafe deliveries and poor birth outcomes, and are unlikely to access postnatal care that helps identify problems mother-infant pairs are facing (e.g. establishing breastfeeding), introduces them to family planning services, and improves awareness of proper feeding and care practices (including vaccination schedules). If new adolescent mothers were in school previously, they are unlikely to return post-delivery, placing them at risk of subsequent unintended pregnancies and higher lifetime fertility rates that feed intergenerational cycles of undernutrition. The underfeeding of pregnant adolescent girls--common in the Samburu context as a strategy to prevent obstructed labor among under-developed, malnourished

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[3] USAID's Passages program aims to address the root challenges of family planning and reproductive health – such as gender-based violence, child marriage, and unintended pregnancy – by transforming social norms.

[4] BRIGE uses three critical areas for women's participation in building resilience: household decision-making, meaningful participation in community groups, and access to market linkages.

young mothers--as well as other taboos in both counties that restrict access to nutritious diets among girls before, during, and after pregnancy, compound the effects of poor access to comprehensive reproductive healthcare services and entrench health and nutrition vulnerabilities of girls and their children.

"*When schools reopened, we had many cases of girls asking for drugs to stop lactation so they could return to school and at the same time our old mamas were crying for [financial] help to take care of these small babies.*" County Government Official, Turkana

Social stigma, lack of emotional support, poor healthcare access, and stress related to new life adjustments have been found in similar contexts to predispose pregnant and parenting adolescent girls--both married and unmarried--to mental health and psychosocial adversities, with implications for self-care and the feeding and care of their children. Young women and men in both counties point to the aggravating effect of food insecurity and drought on the mental health of new parents in the dryland context, and identify mental health as a neglected, priority need of adolescents in general. In both counties, government officials and health workers have observed growing trend in older women (grandmothers) becoming the sole or primary caregiver of newborns and young children, which they attribute to the high burden of pregnancy among unmarried adolescents who are not mentally, emotionally, financially, or physically equipped to parent. In this context, the vulnerabilities and capacities of older women are intimately intertwined with the health and nutrition of adolescents and young children, thus positioning older caretakers as an important and neglected actor in intergenerational cycles of undernutrition.

In response to these findings, USAID Nawiri has elevated pregnant, parenting, and married adolescents, as well as older caregivers of young children, as priority partners in strengthening nutrition resilience in Samburu and Turkana. This decision recognizes that while preventing early pregnancy remains a priority, large populations of already pregnant and parenting adolescents--and their children--present both a risk and opportunity to the sustainable end of P-GAM and wider aspirations of social and economic inclusion in drylands of northern Kenya. (*ToC Reference: IO 1.3.2*) Phase 2 activities will involve building on lessons learned and promising practices from *Binti Shujaa* and similar programs to support pregnant adolescents to access comprehensive services during and after pregnancy, while strengthening their support networks with peers, mentors, and role models. As part of its resilient livelihoods strategy, USAID Nawiri will apply the principles of HCD to facilitate the Ministry of Education, county government, youth-led CSOs, the private sector, and technical training institutes in the collective ideation of solutions, together with pregnant and parenting girls and their parents, that respond to: "*How might we work collaboratively and creatively to provide an enabling environment for parenting and married adolescents, and their children, to reach their potential across multiple domains of wellbeing?* Drawing on learning from Save the Children's Connect program in Tanzania, USAID Nawiri will also explore opportunities to embed within ongoing initiatives, innovative solutions for supporting first-time parents' access to resources and information at scale, including on family planning. In the targeting of financial inclusion and livelihood interventions, including the Rural Entrepreneur Access Project (REAP/graduation model) and VSLAs, USAID Nawiri will give priority consideration to older women who are caring for infants and young children, and will use these activities as platforms for reaching them with tailored information, education, and communication to support optimal self, infant, and young child care and feeding. (*Link to Longitudinal Study Learning Brief*) (*ToC Reference: IO 1.4.2 and Outcome 1.2.1.3a*)

INSIGHT N°3: Accurate knowledge about SRH and positive relationships with parents are critical to adolescents' ability to make positive choices, but may be insufficient to protect and promote ASRH outcomes for adolescents from poor socio-economic backgrounds.

The juxtaposition of a high prevalence of sexual activity with low prevalence of accurate knowledge and pervasive social stigma around adolescent SRH behaviors and outcomes creates a risky sexual health environment for Samburu and Turkana's young people. Adolescents in Samburu and Turkana lack the social autonomy and perquisite knowledge required to make informed decisions about sex, marriage, and childbearing. Myths and misconceptions about SRH, and contraceptive use in particular, are driven by conflicting views, knowledge, and values among parents, teachers, civil society, religious leaders, and healthcare workers, and are perpetuated through peer networks.

Gendered cultural norms and expectations of girls as the agents of population growth, alongside views of pre-marital sex as taboo, deny adolescents access to SRH information and services, thus increasing their vulnerability to early sexual activity, unintended pregnancy, and intergenerational and transactional sex.

"*We discourage young people from injectables [hormonal contraceptives] because they cause infertility.*" - Healthcare worker, Samburu.

Social stigma and fear of social retribution strongly influence adolescent sexual behavior, including how girls manage sexual advances and unwanted pregnancies. The strength and nature of the relationships that adolescents have with their peers, family, and community has direct bearing on how they manage their risk environment, including the strategies they employ to cope and adapt to the pressures they face. Our findings suggest that adolescent-parental relationships that include open communication, trust, and shared goals are particularly important for positive SRH decision-making among adolescents, while poor parent-adolescent communication on SRH issues and negative attitudes of parents toward sexuality are significant risks to adolescent sexual behavior and RH outcomes. Due to labor demands and livelihood needs, parents across all livelihood zones struggle to find time to connect with their children. Further, Samburu and Turkana societies are conservative about discussing sex with children and adolescents, and parents tend to pass the role of sex education to teachers, who are also ill-prepared for the task. Many stakeholders attributed the increase in teenage pregnancy reported during the COVID-19 pandemic to parents' lack of parenting skills and their long-time dependence on teachers to raise their children. "*When schools closed, parents were not prepared. They have always relied too much on teachers to give guidance and discipline--they think it is our job to raise their children. It's high time that parents be parents.*" -Teacher, Turkana Central

While our findings support the important role of accurate knowledge and parent-adolescent relationships for adolescents' agency on SRH, they also suggest that strategies vulnerable households from poor socio-economic backgrounds use to cope with climate-related shocks and stresses and conflict may reduce or dilute the protective effect of knowledge and positive interpersonal relationships on ASRH outcomes. In Turkana, for example, families that lose their livestock due to drought, flooding, animal disease, raids, or poor market prices may rely on their young daughters as a safety net, marrying them off to older men as a restocking strategy. In Samburu, communities respond to conflict by creating territorial protection groups comprising young men and *morans* who might otherwise be in school or further afield with the livestock; bringing *moran* within close proximity to young girls increases co-mingling and the risk of unintended pregnancy. In both counties, transactional sex is a common strategy used by girls living in poverty to meet food and other basic needs. Our findings suggest that transactional

sex may be more common where poverty and (relative) wealth co-exist, such as in Marlal, Lodwar, and tourist destinations in Samburu East, as well as the fishing communities in Turkana's Lake Zone. Girls living in polygamous households may be at greater risk of exposure to transactional sex as result of household coping, but this requires further investigation as part of our learning agenda in Phase 2.

In Phase 2, USAID Nawiri will work to encourage and empower parents and guardians to impart age appropriate sexuality education to their children from an early age, using a dialogue approach that builds trust and empathy and strengthens child-parent relationships. USAID Nawiri will also support safe spaces for adolescent girls and boys to strengthen connections with their peers and trusted mentors, while building life skills that help them navigate their complex realities to achieve their goals. (*ToC Reference: IO 1.3.2*) Working with children and young adolescents to build social capital and emotional identity and help positively reframe boy-girl relationships beginning in early childhood will also be a priority in Phase 2, with far-reaching implications across USAID Nawiri's ToC, including pathways to peaceful co-existence (*ToC Reference: SP 3.4*). Finally, mainstreaming gender in USAID Nawiri's resilient livelihood strategy will help identify opportunities to more deliberately align livelihoods and ASRH objectives for greater impact on nutrition pathways.

INSIGHT N°4: Limited, unequal access to educational opportunities against a backdrop of successful efforts to create demand for education, has created significant societal-level vulnerabilities for risky sexual behavior and early pregnancy, and could reverse gains made in education and socio-economic development more broadly.

Education is recognized as a protective asset for SRH because educational engagement, skills development, and time spent within institutions of learning are typically associated with reduced sexual behavior and exposure to risk. Further, evidence on the importance of girls' education to a range of well-being outcomes is well established. With traditional livelihoods under mounting pressures, parents in Samburu and Turkana increasingly embrace the education of their children with the hope they will secure alternative employment as adults. However, USAID Nawiri's findings suggest that a majority of adolescents in the two counties are unable to optimize educational opportunities as a protective asset; indeed, for some adolescent girls, the pursuit of education may expose them to new risks. For example, adolescent girls from poor households in rural and often conflict-affected areas of Samburu and Turkana who are sent to urban centers to attend day school, and either live with relatives or rent a room, are vulnerable to exploitation, sexual abuse, and early pregnancies. At the same time, these adolescents are isolated from positive interpersonal relationships that would otherwise confer protection. Girls who end up pregnant before marriage become a reproach to their families, and some families would rather keep them away from school to protect them from becoming pregnant.

Equal access to education is further complicated by the concern that girls who move from their rural homes to attend school in towns are separated from their culture and exposed to harmful "western" beliefs. This separation in pursuit of education can be costly for girls over the long term, as they can end up too old for marriage in the cultural context, thereby missing out on the social status accorded to girls who marry early and whose dowry has been paid. In Samburu, adolescent girls may flee their homes to find refuge in schools or rescue centers in order to avoid female genital mutilation and early marriage. Such escapes demonstrate girls' agency and are motivated by their desire to receive an education that they have come to view as a means to a prosperous future. However, limited capacity at these institutions means many girls are turned away, while those who remain must contend with the implications of being cut-off from their parents, peers, family, and community. Finally, our findings

suggest that too-few opportunities for higher education and job opportunities afforded to secondary school graduates is creating doubts among parents and young people alike that the benefits of education outweigh the risks and opportunity costs. "*Many of our youth are idle because they went to school and can't find jobs, nor can they return to their communities because what would they do? School didn't teach them how to herd livestock or take care of a rural home. They belong nowhere in fact.*" Some county stakeholders predict that enrollment and retention in secondary school will begin to reverse until and unless the mismatch between the supply (education system) and demand (labor market) for skills is resolved.

Implication: Learning in Phase 1 suggests that addressing harmful social norms and cultural practices and strengthening life skills that enable adolescents to navigate their dynamic risk environments and optimize their education will be key to reducing early pregnancy and transforming cycles of poverty, inequality, and undernutrition. Enhancing safe and equitable learning opportunities for boys and girls is critical to long-term goals of nutrition resilience, both through education's direct influence on social and economic inclusion pathways, as well as its indirect effects as a platform for integrating nutrition-specific and -sensitive actions, including comprehensive, age appropriate sexuality education and "home-grown" school feeding initiatives. Informed by results of our Labor Markets Assessment, USAID Nawiri will work closely with national and county government stakeholders, private sector, and youth on innovative solutions for addressing the skills gap to enhance local youth employment in sectors that will produce spillover benefits on wider nutrition outcomes, while simultaneously building parents' and adolescents' confidence that the benefits of education outweigh the drawbacks. *(ToC Reference: IO 1.2.1)*

INSIGHT N°5: It's not enough for health services to be "adolescent friendly;" the entire system must be responsive to adolescents' diverse and dynamic needs.

The National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya outlines a package of 20 essential services for adolescents and youth and defines four service delivery models: community-based, clinical-based, school-based, and virtual-based. Aligned to global standards, these guidelines emphasize the need to shift from small-scale adolescent and youth friendly services (AYFS) initiatives to an approach that emphasizes adolescent-responsive health systems. This means that the health system, in all its building blocks, including leadership and governance, health workforce, data quality management, commodities, and financing should be responsive to and address the diverse needs of adolescents and the unique gender-related barriers they face to accessing and receiving quality care. In Samburu and Turkana, USAID Nawiri has identified major barriers to adolescent-responsive service delivery, including inadequate adolescent involvement in policy development, dissemination, implementation, and monitoring at all levels; limited resources and lack of reliable mechanisms to earmark and commit funds for adolescent health and nutrition; limited age disaggregated data (particularly for younger adolescents, 10-14 years as well as for married and pregnant girls); health workers' personal values, attitudes, prejudices, beliefs, and religious persuasions; and limited competencies in adolescent service provision among the health workforce.

The age and gender dimensions of the counties' health workforce is also a key barrier to the health system's responsiveness. In Samburu for example, the *moran* are culturally barred from associating with older or mature women, yet the majority of health workers are women. Misalignment of ASRH policies and guidelines with other multi-sectoral legal and policy frameworks, including the Return to School Policy (1994), for example, present additional impediments to adolescent-responsive service provision and feed the "system of contradictions" that increases ASRH risk, mentioned above. Collectively, these supply-side barriers contribute to limited access to SRH information and services among adolescents,

which in turn serve to further normalize the stigmatization in access to adolescent SRH information and services.

Learning in Phase 1 supports the importance of an adolescent-responsive health system to the sustainable reduction of P-GAM in Samburu and Turkana. In Phase 2, USAID Nawiri will provide technical support to relevant county departments to improve efficiency and effectiveness of adolescent-responsive service delivery, including by strengthening a common framework for multi-sector planning and budgeting and improving the coordination, leadership, and management of the same by the county youth sector working groups. We will work across all health system blocks, with activities that enhance empathy between health workers and young people; strengthen health workers' competencies to provide adolescent-responsive services, including values and attitudes clarification; and improve accessibility of contraceptives. USAID Nawiri will also build the capacity of CSOs in advocacy and social accountability to amplify the voices of adolescents and young people in the domestication and dissemination of relevant policies, and, in their meaningful involvement in holding the system accountable for the delivery of health and other services that meet their needs, year-round and during shocks. (*ToC Reference: Outcome 2.2.1.1*).

CONCLUSION & PRIORITY AREAS FOR CONTINUED LEARNING

Only by working together with adolescent girls and boys to understand their needs and aspirations and illuminate the reality of their lives can external actors hope to make real change possible. This is more of a lesson reinforced than a lesson learned, but is nonetheless foundational to USAID Nawiri's strategy for Phase 2 that sees us harnessing the positive potential of young people to transform intergenerational cycles of poverty and undernutrition and accelerate progress in counties' journey to self-reliance. Learning during Phase 1 supports USAID Nawiri's theory that the drivers and effects of early pregnancy, and poor SRH outcomes more broadly, are strongly implicated in the complex causality of P-GAM in the Samburu and Turkana context. The participatory learning journey also exposed key leverage points where, through a combination of programming, partnership, and advocacy directed at addressing the drivers and effects of early pregnancy, USAID Nawiri stands to make a significant contribution to the sustainable end of wasting in Samburu, Turkana, and the drylands of northern Kenya more broadly. Phase 2 design will integrate principles and practices of collaboration, learning, and adaptation (CLA) to continue to build the evidence base and contribute to the capacity of USAID Nawiri and partners to strengthen normative environments that support reproductive health and well-being, in tandem with nutrition resilience. In addition to very young, pregnant, and parenting, and/or married adolescents, USAID Nawiri will also leverage early and middle childhood as key life-course transition points to drive collective, sustainable impact at scale.

Priority areas for continued, adaptive learning in Phase 2 include but are not limited to the following lines of inquiry: (1) How do peer relationships indirectly influence an adolescent's execution of agency in managing their risk environment, including negotiating sexual encounters? (2) How might USAID Nawiri leverage existing community structures and systems to create synergies that optimize benefits for the physical, cognitive, and socio-emotional development of individuals in early and middle childhood? (3) How can participatory learning approaches be designed and executed to build social capital (bridging, bonding, linking), strengthen analytical and problem-solving skills, and promote psychosocial well-being among individuals at key life-course transition points?

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