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"We don't fear HIV. We just fear walking around pregnant.": A qualitative analysis of adolescent sexuality and pregnancy stigma in informal settlements in Kisumu, Kenya

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Abstract

In Kenya, adolescent pregnancy rates are high, contraception utilization is low, and adolescent sexuality is stigmatized. We describe how perceptions of sexuality and pregnancy stigma influence decision-making among adolescents in the informal settlements of Kisumu. We used purposive sampling to recruit 120 adolescent boys and girls ages 15-19 for focus group discussions. A semi-structured interview guide was used to elicit social norms and community attitudes about sexual and reproductive health. We analyzed the data using the Framework Approach. The social stigma of adolescent sexuality and the related fear of pregnancy as an unambiguous marker of sexual activity emerged as main themes. This stigma led adolescents to fear social retribution but did not lead to more frequent contraception use due to additional stigma. The intensity of this fear was most acutely expressed by girls, leading some to seek unsafe, sometimes fatal, abortions, and to contemplate suicide. Fear of pregnancy outweighed fear of contracting HIV which was viewed as both treatable and less stigmatized. Our findings illustrate how fear of pregnancy among these adolescents is driven primarily by fears that their community will discover that they are sexually active. Interventions are urgently needed to address adolescent sexual stigma and to prevent negative outcomes.

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Introduction

Social norms around sex, contraception, pregnancy, and abortion have a significant impact on the decision making of adolescents ages 15-19 years (Moseson et al. 2019; Smith et al. 2017). Social norms are what is considered acceptable behavior within a community, while social stigma is disapproval and retribution when those norms are violated (Bicchieri 2006; Goffman 1959). In general, social stigma does not lead to decreased adolescent sexual activity but rather decreased disclosure of behavior and use of contraceptives, and increased feelings of social isolation (Kinaro et al. 2015; Håkansson et al. 2020; Rice et al. 2018; Kaljee et al. 2007). Fearing social stigma, some adolescents conceal their pregnancies, make decisions without social support, seek unsafe abortions, and/or experience suicidal ideation (Smith et al. 2017; Crowley, High, and Thomas 2019).

Globally, 10% of all births are to girls and young women under 20 and more than 90% of these births occur in low-and-middle income countries (World Health Organization 2017; Mayor 2004). In Kenya, as in other sub-Saharan African countries, adolescent pregnancy rates are high, contraception utilization is low, and adolescent sexuality is socially stigmatized (Akwara and Idele 2020; Kenya National Bureau of Statistics et al. 2015). Among respondents ages 20 – 49 of the 2014 Kenya Demographic and Health Survey (DHS) in Kisumu County, in the western region of Kenya, the median age of sexual debut was 16.4 for women and 17.9 for men. Among respondents ages 20 – 24, 47% of women and 57% of men had sexually debuted before 18, and 13.6% and 22.6%, respectively, before 15, illustrating the prevalence of adolescent sexual activity in the region (Kenya National Bureau of Statistics et al. 2015).

Despite the high prevalence of adolescent sexual activity in Kisumu County, contraception is highly stigmatized and underutilized, with 50% of sexually active unmarried adolescents reporting no method used (Kenya National Bureau of Statistics et al. 2015). Social, cultural, and religious taboos lead to a lack of sexual and reproductive health (SRH) dialogue between adolescents and their parents, teachers, and clinicians, with 92% of adolescents in Kenya reporting that they had never discussed family planning with a healthcare worker (Kenya National Bureau of Statistics et al. 2015; Hagey et al. 2015; Akwara and Idele 2020; Mitchell, Jonas-Simpson, and Ivonoffski 2006; Jayaweera et al. 2018). A recent survey of teachers and peer-counselors in Kisumu found that one-third of respondents believed contraceptives cause infertility, encouraged promiscuity, and that adolescent girls cannot make their own decisions about use, highlighting the limited access adolescents in the region have to evidence-informed counsel (Håkansson et al. 2020).

In Kisumu County, the median age at initial birth was 19.6 years among women ages 25–29, with 15% of women giving birth up to three times before age 19 (Kenya National Bureau of Statistics et al. 2015). A 2012 study found that 49% of all pregnancies in Kenya were unintended and 41% of those pregnancies ended in abortion (Mohamed 2015). Safe, medical abortions are rare in Kenya with the majority performed illegally by private providers who may or may not be medically trained, or through various methods of self-induction including insertion of objects into the cervix, ingesting poison or drug overdoses, extreme physical exertion, or abdominal blunt force (World Health Organization 2011; Center for

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Reproductive Rights 2010). Data disaggregated by age were not available, however a study in Nairobi found that of 50 young women (under the age of 24) who had an abortion, 95% of the abortions were considered unsafe (Kenya Human Rights Commission 2010).

The juxtaposition of the high prevalence of sexual activity with pervasive stigma around adolescent SRH creates a precarious sexual health environment. Through focus group discussions (FGDs), we explored social norms and stigma around sexuality, contraception, pregnancy, and abortion among adolescents.

Methods

The Maneno Yetu study was conducted in Kisumu, Kenya, and aims to understand the core values and communication styles that adolescents use when discussing sex, pregnancy, family planning, abortion, and sexually transmitted infections (including HIV) (Zamudio-Haas et al. 2021). We sought to describe the social norms and their impact on the lives of adolescents. Fourteen FGDs were conducted from February-April 2019 in the informal settlements, i.e., “slums”, of Obunga, Manyatta, Bandani and Nyalenda (Zamudio-Haas et al. 2021; Truong et al. 2021).

Study population

The Kisumu region of Kenya borders Lake Victoria, where the majority of the population are members of the Luo and Luhya tribes. It is predominantly a fishing region with several large universities and hospitals providing additional employment. The communities included in the study are on the periphery of the city with mostly mudbrick housing, few indoor latrines, and multiple families per home. Adolescents enrolled in secondary school attend mostly boarding schools in the surrounding region although a few local day schools exist. HIV prevalence among adolescents living in Western Kenya is high compared to other parts of the country and HIV is the leading cause of mortality among adolescents in this region (WHO 2016). Other health risks to adolescents include road traffic accidents, early marriage, transactional sex relationships, limited access to contraceptives, healthcare stigma, diarrheal diseases, and malaria (WHO 2016).

Data collection

We purposively sampled participants from community health volunteer referrals. The parameters for the purposive sampling included a) residing in a study community and b) being 15-19 years of age. Parents provided consent for participants ages 15-17 whereas participants ages 18-19 self-consented. The research assistants (RAs) used a semi-structured interview guide with questions, prompts, and vignettes with narratives related to SRH health topics. The vignettes were included for participants to discuss SRH issues with the protagonist of the narrative serving as a proxy for themselves. Shown below is the introduction to a sample vignette:

> Auma is a sixteen-year-old girl from a family of eleven children. One evening she was going home from the market when a very sleek car stopped beside her. The owner, a very rich looking middle-aged man, asked her if he could give her a ride…

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The questions were designed to elicit social norms and community attitudes, although some individual behaviors and attitudes were expressed by participants. The guide was designed through a collaborative process between the Kenyan RAs and US-based investigators.

FGDs were stratified by both sex and age (15-17, 18-19). Groups for out-of-school boys and girls, and adolescent mothers were also convened to capture a broader range of perspectives. Kisumu-based RAs facilitated the FGDs in a combination of English, Kiswahili, and Dholuo. Two gender-paired RAs were present for each group with one leading the discussion and the other serving as a notetaker. The guide was piloted in a community not included in the study and appropriate adjustments made to the guide before launch. Participants were provided with 300 KSH (~$3USD) as transportation reimbursement. The study received approval from the institutional review boards of the University of California San Francisco and Kenya Medical Research Institute.

Analysis

Data analysis was conducted jointly by study team members based in the US (HMT, SZH, CA, LEM) and Kenya (BO, SA, DO, IA, KK, HO). The RAs were trained by qualitative researchers from UCSF (SZH) and UC Berkeley (CA) in coding, tabling, and memo writing.

The FGDs were audio recorded, transcribed, and translated into English for analysis by a Kisumu-based translator. No patient or public involvement was sought when designing the FGDs. The five phases of Framework analysis lead our qualitative process. In phase 1, the RAs immersed themselves in the data by reading and re-reading the transcripts. In phase 2, the study team developed a thematic framework based on the Social Ecological Model and created a codebook of deductive and inductive codes (Bronfenbrenner 1979, 1986). We coded all transcripts using the codebook through the Dedoose software platform in phase 3 and analyzed the code reports and organized the data into tables based on emerging themes in phase 4. In phase 5, the study team drafted memos exploring themes and comparing perceptions of adolescents across age and gender groups.

Results

There were 120 FGD participants, of whom 68 (56.7%) were girls, and most were single, in school, and not working (Table 1). Our main themes explored the social stigma of adolescent sexuality and fear of pregnancy as an unambiguous marker of sexual activity. Subthemes included pregnancy as a more feared outcome of sexual activity than contracting sexually transmitted infections (STIs) and HIV. Adolescents' reported fear of pregnancy did not lead to more frequent contraception use due to the stigma experienced in attempting to access contraceptives. The intensity of this fear was most acutely expressed by girls, leading some to seek unsafe, sometimes fatal, abortions, and to contemplate suicide rather than experience the public shame of carrying a pregnancy to term. Respondents discussed the experiences of girls who carried their pregnancies to term and the healthcare practitioner stigma they experienced during antenatal and intrapartum care.

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Overview of social norms

Sexual activity discussed ranged from consensual sex with peers and older partners, to forced and transactional sexual encounters. While some spoke from personal experience, most discussed sex and pregnancy in the abstract, recounting stories of people they knew or repeating stories heard about others. Social norms were conveyed more often through a discussion of stigma than the norms themselves and participants spoke of sex generally as a culturally taboo subject.

> In this community that we live in, sex has been made to look like a taboo. People know that they are not supposed to talk about sex and that is why even children are told that they are 'doing bad manners.' It is even rare to get married people discussing about sex.
>
> - Girl, age 18, Manyatta

Participants expressed the belief that an adolescent pregnancy would bring shame upon the family and destroy the family reputation within the community. Many spoke of how the girls are now 'mothers' and therefore no longer in need of parenting themselves and should be expected to care for themselves financially and emotionally. Pregnancy was considered to be an embarrassment for the family.

Boys spoke of judgement from the girls' family, fearing they will say, 'this is the one who spoiled our child' as well as fear of needing to leave school, having the resources to support the child, and possible retribution from the community chief. They spoke of loneliness, low morale, familial rejection, and the inability to 'enjoy life' after impregnating someone.

> You know there is this issue of enjoying life. Boys want to live their life to the fullest. So by the time you have impregnated a girl you will be forced to start looking for money to feed someone with her child.
>
> - Boy, age 18, Nyalenda

Girls spoke of feeling ashamed to be pregnant and still living with their parents. Not knowing whether their family would tell them to 'pack your things and go where you got the pregnancy from' or 'should I just go and get married or what?' Girls who were already adolescent mothers spoke of the shame their parents feel, with one participant saying:

> [My mother] will be ashamed of having a grandchild at an early age…and she could be comparing herself with her friends and she will feel that her friends' daughters have never been pregnant.
>
> - Girl, age 18, adolescent mother, Nyalenda

In addition to fears of social stigma directed towards themselves, certain boys spoke of their own judgements of adolescent girls who became pregnant. They discussed how a girl's 'beauty will end' and her 'value' will decrease – both in terms of social freedoms and future romantic or sexual partners. They also expressed judgement of the lifestyles of sexually active adolescent girls citing 'life in the fast lane' as the reason for the unintended pregnancy and referring to certain girls as 'slay queens,' a colloquialism referring to an adolescent girl who dresses well, often spending more than what she or her family can afford in order to attract the attention of more wealthy adolescent boys or older men.

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> If the girl was a slay queen and she is pregnant that slaying will have to end because she is now a mother and she won't be anybody's crush in the estate. If she was the star of estate she will now be looked at as "kwenda uko" (as a nobody).
>
> - Boy, age 18, Nyalenda

Once a girl becomes pregnant, boys said the girl becomes a "woman" and is no longer seen as a peer.

Stigma of adolescent sexuality leads to fear of pregnancy

Adolescents across groups spoke of general community stigma towards adolescent pregnancy with girls fearing 'walking around pregnant' and boys fearing that people would point and say, 'there is the impregnator.' Fear of pregnancy eclipsed fear of HIV and STIs as other consequences of sexual activity, with both perceived as treatable and concealable compared to pregnancy.

> What girls fear is pregnancy, they don't care about HIV and STIs. What they fear is what people in the community will say about them when they get pregnant.
>
> - Girl, age 18, Bandani

> Sex is not even the issue. Most girls fear getting pregnant. You know when you get HIV, there are drugs that suppress the virus (ARVs), that is why we don't fear HIV. We just fear walking around pregnant.
>
> - Girl, age 18, Bandani

Boys spoke of the judgement they would receive from their communities and the disappointment their families would feel in them. One participant describes it as a lonely state having lost the trust of his family:

> You know to start with, if you hear that a girl is pregnant for you and your mother trusted you that trust will end. So you will not be trusted by anyone in the house and you will be lonely and the morale that you had will be completely gone.
>
> - Boy, age 18, Nyalenda

Fear of embarrassment and social stigma were mentioned more often by both girls and boys than consequences of raising a child or the effect on the adolescent's life and future prospects. Fearing 'people will laugh at you [and] this will be so embarrassing' was the pervasive feeling shared by participants.

Stigma restricts contraceptive use leading to unsafe abortions and suicide

Contraception—Only two forms of contraception were mentioned as accessible to participants: condoms and emergency contraception or 'P2.' Condoms were available at local shops and grocery stores whereas P2 needed to be procured from clinics or chemists/pharmacists. Both girls and boys spoke of embarrassment and fear of judgment in seeking contraception as shopkeepers or clinic staff will 'go and tell your mother' or 'ask you very many questions.'

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> I feel that if you go directly, it will cause problems. You never know if the person who is selling the drug is your parent's friend… [They] will start pestering you, 'What do you want to do with it?'
>
> - Boy, age 17, out-of-school, Bandani

To avoid embarrassment, participants spoke of giving an alias, claiming they were buying for a cousin, or going to a different town to not be recognized. Boys spoke more about acquiring both P2 and condoms than girls, except for adolescent mothers who recounted similar experiences.

Older girls referred to the relative lack of education and understanding of contraceptive methods and options for younger girls, saying that they generally do not use family planning methods and if they become pregnant will deny it until they begin to show.

> It depends on what age you are at. Maybe you have rushed and had sex at an early age and you don't even know that things like P2 exists or you don't have that close friend that you can share with your problems.
>
> - Girl, age 19, Manyatta

Abortion—According to participants, fear and/or experience of stigma led some girls to resort to unsafe abortions that were sometimes fatal. 'Abortion' most often referred to going 'to a traditional medicine man' where he 'will give you herbs to drink,' drinking a mixture of 'Omo' (laundry detergent) and water, or inserting sharp objects into the cervix, saying 'you can tamper with anything in your uterus which can result in over bleeding.' Few participants mentioned using a medical provider with only one saying, 'they are available… we have a chemist around here that has a clinic at the back.'

Out-of-school girls and adolescent mothers were more likely to speak of their personal experiences or of people they knew compared to in-school girls who spoke about abortion in general or what 'some' girls do. Several participants recounted stories of girls pressured into unsafe abortions by family members, which in some cases led to the girl's death.

> I have seen a girl who tried abortion. She was living with her grandmother and she told her "you have to have an abortion because you are going to sit for your form four examinations". The grandmother made for her Omo to drink. She started bleeding and when she was rushed to the hospital she died on arrival. She was six months pregnant.
>
> - Girl, age 18, adolescent mother, Nyalenda

Older boys were more likely than younger boys to suggest an abortion should a partner become pregnant, even if they recognized that it was a risky procedure. They spoke of being concerned about continuing their studies, therefore encouraging girls to seek abortions.

> The best thing is to terminate the pregnancy because if you are also a student it bothers you. The girl cannot go to school while pregnant because in school fellow students will not see her pregnant and keep quiet, they will be laughing. You will have given them something to laugh about, so what you can do is to terminate the pregnancy you continue with your normal life.

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- Boy, age 19, Obunga

Younger boys, likely with less personal experience impregnating someone, were more judgmental, saying abortion was 'not a good thing.' They perceived it to be 'rampant in the community' and the 'most common option'.

> Abortion is rampant in this community despite the fact that it's a bad thing. One minute a girl is pregnant the next minute she has had an abortion. It's hard to trust these girls. They are the only ones who know who is responsible for the pregnancy.
>
> - Boy, age 17, Obunga

Suicide

Both boys and girls spoke of peers or stories they heard from the community about pregnant girls who committed suicide. Girls spoke of the shame and harassment pregnant girls encounter, some even speaking in the first person.

> That is the time that we girls think of suicide. So many things are going on through the mind of the girl when she is suspecting that she is pregnant. At first it is always very hard to decide, you don't know whether to abort or kill yourself or even what to do. That is how some girls end up doing some bad things.
>
> – Girl, age 18, Manyatta

Adolescent mothers recounted stories of stigma, from 'harsh' family members in particular, as the primary driver for suicide. Stories described girls fighting with parents about the pregnancy and choosing suicide over an abortion imposed by parents. Some girls seeking advice from their family are 'chased away,' leaving them feeling they have no option other than suicide.

> Suicide is usually because of the parents… They will ask "who told you to get pregnant? Let us go for an abortion." They will be forcing you to abort but you don't want to because you had told your friends that you are pregnant and with time they will start wondering why your pregnancy is not showing. When they realize that you had an abortion, they will start insulting you. So because your parents are forcing you to have an abortion, you may decide, "I would rather commit suicide so that I die with my baby."
>
> – Girl, age 18, adolescent mother, Nyalenda

As noted in the quote above, motivations for suicide can include parental pressure to abort and fear of abortion stigma from peers and community members. Some girls rejected this behavior, 'I cannot kill myself because life has to continue.' These girls mentioned seeking help from gender-based violence centers or other family members such as an aunt or older cousin if parents are too harsh.

Some boys, mostly out-of-school, spoke of committing suicide themselves, particularly to avoid punishment from the local chief (the leader of the community) who might beat or otherwise punish a boy for impregnating an adolescent girl.

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> The chief will cane you mercilessly…in front of people and that is when you will find someone committing suicide. The way they will come for you early in the morning and maybe you went to bed naked, you will be exposed to people along the road in the estate… That will be challenging because everyone will see you and you will start thinking, “These people will look down upon me. How will they take me?” you just find yourself committing suicide.
>
> - Boy, age 17, out-of-school, Bandani

Social isolation and healthcare stigma

If a girl chooses to carry a pregnancy to term, often she will continue to avoid social interactions to hide her pregnancy and shield herself from stigma. One participant spoke of a girl telling her friends that she moved to a different town but instead stayed inside her house for the duration of her pregnancy, and sought antenatal care in a neighboring town so word of her pregnancy would not reach her community. Pregnant girls will often hide their pregnancy and be forced to make decisions in isolation without support from friends, family, and the child’s father.

> …Most girls are normally so secretive. She might suspect that she is pregnant but fear going to tell her boyfriend or any other person. She is just in her corner and not talking. Sharing with someone is usually very difficult to some of us.
>
> - Girl, age 19, out-of-school, Manyatta

Respondents related that girls who chose or were forced to carry the pregnancy to term faced stigma in healthcare settings, often from nurses. Adolescent mothers recounted their own birth experiences, saying nurses would ‘throw bitter words’ at them asking, ‘Did I tell you to go and spread your legs?’ The mothers spoke of being yelled at during their labor, with hostile nurses saying, ‘Stop making noise! When you were enjoying were we with you? Shut up!’ These statements reflect the severe judgement pregnant adolescents face in the healthcare setting, even while giving birth.

Discussion

The fear of pregnancy among adolescents in Kisumu is driven primarily by fears that their community will discover their sexual activity. Our findings build upon previous research examining social stigma of adolescent SRH by adding nuance to the intensity of the fear and how it affects behaviors, with sometimes fatal consequences (Moseson et al. 2019; Smith et al. 2017; Rice et al. 2018; Kaljee et al. 2007; Akwara and Idele 2020; Hall et al. 2018; Levandowski et al. 2012). Inclusion of perspectives from boys and the FGD format where social norms were intentionally explored provides new insights on SRH stigma and the focus on abortion and suicide prevalence are novel insights.

The finding that adolescents’ fear of pregnancy outweighs fear of HIV is particularly interesting as HIV is the leading cause of mortality for Kenyan adolescents (World Health Organization 2016). Programs and interventions to combat HIV stigma have built an infrastructure of clinical and psychosocial support for HIV patients that have given adolescents the impression that HIV is a treatable illness and can be openly discussed

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without fear of social retribution (Akwara and Idele 2020; Yakubu and Salisu 2018; Kassa et al. 2018; Hindin et al. 2016; Mugwanya et al. 2019). HIV status does not necessarily reflect sexual experience as adolescents may have contracted HIV through mother-to-child transmission (or claim s/he did). Pregnancy, conversely, necessitates the discussion of sex, a topic that is difficult to discuss with any adult, but especially clinicians who are likely to judge the adolescent's behavior.

Our observations regarding unsafe abortions, combined with the frequent discussion of suicide, speaks to the desperation adolescent girls feel and the lengths they are willing to go to avoid carrying a pregnancy to term (Håkansson et al. 2020; Jayaweera et al. 2018; Levandowski et al. 2012; Espinoza, Samandari, and Andersen 2020). Although discussions of staying in school or not yet wishing to be a parent were mentioned, most girls spoke of taking these extreme measures to avoid stigma and social consequences.

There were marked differences in how boys spoke about SRH as compared to girls and how each group was treated by the community. Overall, boys were more talkative about SRH issues than girls and more likely to recount personal experiences. Girls faced harsher social consequences for adolescent sexual activity, with more severe judgement from their communities as well as their male peers and partners. The option to deny paternity in the community gave boys more sexual freedom and fewer long-term consequences. Our findings, however, also highlight that boys do still experience personal and social consequences for having sex at their age including instances of being ostracized by their families and receiving punishment, sometimes in the form of physical violence, from the village chief.

Investing in services that help reduce adolescent pregnancy is critical. Existing evidence-based interventions, such as adolescent sexual health education, increasing access to contraception and medical abortions and promoting school retention, can significantly reduce adolescent pregnancy (Zamudio-Haas et al. 2021; World Health Organization 2018; Sama, Ngasa, and Dzekem 2017; Yakubu and Salisu 2018). Focusing solely on adolescents, however, is less effective than engaging the whole community through public awareness campaigns, especially ones urging parents and clinicians to address their own biases and communicate more effectively with adolescents (Kassa et al. 2018; Hindin et al. 2016). Fear of stigmatization by healthcare workers prevents some adolescents from seeking SRH services. This barrier can be reduced by including contraceptive counseling in routine healthcare for adolescents living with HIV, scheduling adolescent-only clinic days, or building stand-alone clinics with staff trained to provide a range of adolescent-appropriate services (Håkansson et al. 2020; Hagey et al. 2015; Mugwanya et al. 2019). Addressing community stigma towards adolescent sexuality is far more complex, requiring slow and systemic change. The development of interventions to address these issues could be modeled after successful HIV stigma interventions, but more testing and research in this area is greatly needed.

Limitations

There were several limitations to this study. FGDs are less private than interviews and participants, particularly girls, may have been less comfortable discussing topics that

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might draw judgement from the group. Recruitment through community groups may have introduced selection bias by the referrals and may have yielded participants with more connected social support, thus missing more vulnerable adolescents. A strength of the study was including an adolescent mothers' group, although we would have also benefitted from conducting an adolescent fathers' group.

Conclusions

The fear of stigma drives adolescents to conceal true sexual behavior from their families and community, leading to low usage of contraception and sometimes unsafe abortion and suicide. Comprehensive SRH education and services, and community sensitization campaigns are urgently needed to address adolescent SRH stigma. The HIV community has been effective in combating stigma and normalizing health seeking behaviors. Similar resources, programs, and prioritization should be placed on reducing adolescent SRH stigma and facilitating access to critical education and services.

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Research data are not shared

References

Akwara Elsie, and Idele Priscilla. 2020. "The Moral and Social Narratives of Sexual and Reproductive Health in Kenya: A Case of Adolescents and Young People Pre- And within the MDG Era." Reproductive Health 17 (1): 1–12. [PubMed: 31915022]

Bicchieri C 2006. The Grammar of Society: The Nature and Dynamics of Social Norms. New York, NY: Cambridge University Press.

Bronfenbrenner U 1977. "Toward an Experimental Ecology of Human Development." Am. Psychol. 32 (513).

—. 1986. "Ecology of the Family as a Context for Human Development: Research Perspectives." Developmental Psychol. 22 (6): 732–42.

—. 1989. "Ecological Systems Theory." In Annals of Child Development, edited by Vasta R, 187–249. London, UK: Jessica Kingsley Publishers.

Center for Reproductive Rights. 2010. "In Harm's Way: The Impact of Kenya's Restrictive Abortion Law." New York, NY.

Crowley Jenny L, High Andrew C, and Thomas Lindsey J. 2019. "Desired, Expected, and Received Support: How Support Gaps Impact Affect Improvement and Perceived Stigma in the Context of Unintended Pregnancy." Health Communication 34 (12): 1441–53. [PubMed: 29985638]

Espinoza Cecilia, Samandari Ghazaleh, and Andersen Kathryn. 2020. "Abortion Knowledge, Attitudes and Experiences among Adolescent Girls: A Review of the Literature." Sexual and Reproductive Health Matters 28 (1).

Goffman Erving. 1959. The Presentation of Self in Everyday Life. Garden City, NY: Doubleday.

Hagey Jill M., Akama Eliud, Ayieko James, Bukusi Elizabeth A., Cohen Craig R., and Patel Rena C.. 2015. "Barriers and Facilitators Adolescent Females Living with HIV Face in Accessing Contraceptive Services: A Qualitative Assessment of Providers' Perceptions in Western Kenya." Journal of the International AIDS Society 18 (1): 1–8.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Håkansson Miranda, Super Stephanie, Oguttu Monica, and Makenzius Marlene. 2020. "Social Judgments on Abortion and Contraceptive Use: A Mixed Methods Study among Secondary School Teachers and Student Peer-Counsellors in Western Kenya." BMC Public Health 20 (1): 1–13. [PubMed: 31898494]

Hall Kelli Stidham, Manu Abubakar, Morhe Emmanuel, Dalton Vanessa K., Challa Sneha, Loll Dana, Dozier Jessica L., Zochowski Melissa K., Boakye Andrew, and Harris Lisa H.. 2018. "Bad Girl and Unmet Family Planning Needs Among Sub-Saharan African Adolescents: The Role of Sexual and Reproductive Health Stigma." Qualitative Research in Medicine & Healthcare 2 (1): 55–64. [PubMed: 30556052]

Hindin Michelle J., Kalamar Amanda M., Thompson Terri Ann, and Upadhyay Ushma D.. 2016. "Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature." Journal of Adolescent Health 59 (3): S8–15.

Jayaweera Ruvani T., Ngui Felistah Mbithe, Hall Kelli Stidham, and Gerdts Caitlin. 2018. "Women's Experiences with Unplanned Pregnancy and Abortion in Kenya: A Qualitative Study." PLoS ONE 13 (1): 1–13.

Kaljee Linda M, Green Mackenzie, Riel Rosemary, Lerdboon Porntip, Tho Le Huu, Thi Le, Thoa Kim, and Minh Truong Tan. 2007. "Sexual Stigma, Sexual Behaviors, and Abstinence Among Vietnamese Adolescents: Implications for Risk and Protective Behaviors for HIV, Sexually Transmitted Infections, and Unwanted Pregnancy." Journal of the Association of Nurses in AIDS Care 18 (2): 48–59.

Kassa Getachew Mullu, Arowojolu AO, Odukogbe AA, and Yalew Alemayehu Worku. 2018. "Prevalence and Determinants of Adolescent Pregnancy in Africa : A Systematic Review and Meta-Analysis." Reproductive Health 15 (195): 1–17. [PubMed: 29304829]

Kenya Human Rights Commission (KHRC). 2010. "Teenage Pregnancy and Un-Safe Abortion: The Case of Korogocho Slums." Nairobi, Kenya.

Kenya National Bureau of Statistics, Ministry of Health/Kenya, National AIDS Council/Kenya, Kenya Medical Research Institute, and National Council for Population and Development/Kenya. 2015. "Kenya Demographic and Health Survey 2014." Rockville, MD.

Kinaro Joyce, Kimani Murungaru, Ikamari Lawrence, and Ayiemba Elias H O. 2015. "Perceptions and Barriers to Contraceptive Use among Adolescents Aged 15 - 19 Years in Kenya : A Case Study of Nairobi." Health 7: 85–97.

Levandowski Brooke A, Kalilani-phiri Linda, Kachale Fannie, Awah Paschal, and Kangaude Godfrey. 2012. "Investigating Social Consequences of Unwanted Pregnancy and Unsafe Abortion in Malawi : The Role of Stigma." International Journal of Gynecology and Obstetrics 2: 167–71.

Mayor S 2004. "Pregnancy and Childbirth Are Leading Causes of Death in Teenage Girls in Developing Countries." British Medical Journal 328 (7449): 1152.

Mohamed Shukri, Izugbara Chimaraoke, Moore Ann M., Mutua Michael, Kimani-Murage Elizabeth W., Ziraba Abdhalah K, Bankole Akinrinola, Singh Susheela D and Egesa Caroline. 2015. The estimated incidence of induced abortion in Kenya: a cross-sectional study. BMC Pregnancy and Childbirth 15:185. [PubMed: 26294220]

Moseson Heidi, Mahanaimy Moria, Dehlendorf Christine, and Gerdts Caitlin. 2019. "' … Society Is , at the End of the Day , Still Going to Stigmatize You No Matter Which Way ': A Qualitative Study of the Impact of Stigma on Social Support during Unintended Pregnancy in Early Adulthood." PLoS ONE 14 (5): 1–14.

Mugwanya Kenneth K., Pintye Jillian, Kinuthia John, Abuna Felix, Lagat Harrison, Begnel Emily R., Dettinger Julia C., John-Stewart Grace, and Baeten Jared M.. 2019. "Integrating Preexposure Prophylaxis Delivery in Routine Family Planning Clinics: A Feasibility Programmatic Evaluation in Kenya." PLoS Medicine 16 (9): 22–29.

Rice Whitney S, Turan Bulent, White Kari, and Turan Janet M. 2018. "Norms and Stigma around Unintended Pregnancy in Alabama: Associations with Recent Contraceptive Use and Dual Method Use among Young Women." Women & Health 58 (10): 1151–66. [PubMed: 29240532]

Sama Carlson-babila, Ngasa Stewart Ndutard, and Dzekem Bonaventure Suiru. 2017. "Prevalence, Predictors and Adverse Outcomes of Adolescent Pregnancy in Sub-Saharan Africa: A Protocol of a Systematic Review." Systematic Reviews 6 (247): 1–6. [PubMed: 28077170]

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Smith Whitney, Turan Janet M., White Kari, Stringer Kristi, Helova Anna, Simpson Tina, and Cockril Kate. 2017. "Social Norms and Stigma Regarding Unintended Pregnancy and Pregnancy Decisions: A Qualitative Study of Young Women in Alabama." Perspectives on Sexual and Reproductive Health 48 (2): 73–81.

Truong Hong-Ha M., A Rain Mocello David Ouma, Bushman Dena, Kadede Kevin, Ating'a Eric, Obunge Duncan, Bukusi Elizabeth A., Odhiambo Francesca, and Cohen Craig. 2021. "Community-Based HIV Testing Services in an Urban Setting in Western Kenya: A Programme Implementation Study." Lancet HIV Jan 8(1): 16–23.

World Health Organization. 2017. "Adolescents: Health Risks and Solutions." Geneva, Switzerland. Accessed February 22, 2021. http://www.who.int/mediacentre/factsheets/fs345/en/%0A2.

World Health Organization. 2016. "Adolescent Mortality Ranking - Top 5 Causes (Kenya)." Maternal, Newborn, Child & Adolescent Health. 2016. Accessed February 22, 2021. https://www.who.int/data/maternal-newborn-child-adolescent/indicator-explorer-new/mca/adolescent-mortality-ranking---top-5-causes-(country).

World Health Organization. 2018. "Adolescent Pregnancy Fact Sheet." 2018. Accessed February 22, 2021. http://www.who.int/mediacentre/factsheets/fs364/en/.

World Health Organization. 2011. "Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, Sixth Ed." Geneva, Switzerland.

Yakubu Ibrahim, and Salisu Waliu Jawula. 2018. "Determinants of Adolescent Pregnancy in Sub-Saharan Africa: A Systematic Review." Reproductive Health 15 (15).

Zamudio-Haas Sophia, Auerswald Collette, Miller Lara, Amboka Sayo, Agot Irene, Kadede Kevin, Otieno Beatrice, et al. n.d. 2021 "Seeking a 'Sponyo': Insights into Motivations and Risks Around Intergenerational Transactional Sex among Adolescent Boys and Girls in Kenya." Journal of Adolescent Health 68(5):930–936.

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TABLE 1

Demographic characteristics of focus group discussion participants (N=120)

Characteristics	Total	Sex	
		Male	Female
All Participants	120	52	68
Age			
15-17	54	23	31
18-19	66	29	37
Community			
Bandani	17	8	9
Manyatta	33	17	16
Nyalenda	32	16	16
Obunga	38	27	11
Education status			
Attending school	62	23	39
Out-of-school	58	29	29
Employment status			
Currently working	11	7	4
Currently not working	109	45	64
Relationship status			
Single	104	41	63
Committed relationship	12	8	4
Married	2	1	1
Separated	1	1	0