Early and unintended pregnancy in Eastern and Southern Africa: analysis of adolescent sexual and reproductive health and rights policies

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ABSTRACT
In 2019, there were 21 million pregnancies among adolescents aged 15–19 years globally; close to half of these pregnancies were unintended. Early and unintended pregnancy (EUP) remains a pressing concern with severe socioeconomic and health outcomes for adolescent girls aged 15–19 years, their offspring and society. Early and unintended pregnancy (EUP) remains a pressing concern with severe socioeconomic and health outcomes for adolescent girls aged 15–19 years, their offspring and society. In Eastern and Southern Africa (ESA), Zambia, the United Republic of Tanzania, the Democratic Republic of Congo, Malawi and Uganda have adolescent fertility rates (AFR) of more than 100 live births per 1000 adolescent girls aged 15–19 years. Ministers of Health and Education, through the ESA Ministerial Commitment, aimed to reduce EUP by 75% by 2020; the renewed ESA Ministerial Commitment aims to reduce EUP by 40% by 2030. This descriptive policy content analysis assesses the prioritisation of EUP within adolescent sexual and reproductive health and rights (ASRHR) policies. An assessment of nine countries in the region shows that EUP is a key policy priority among countries; however, other than Kenya, the majority of ASRHR policies in the region do not set out clear and costed interventions for EUP, and few have monitoring and evaluation frameworks in place. Despite AFRs declining in Kenya and strong policies in place, the gains made are at risk due to the rollback on SRHR, and the country has not renewed the ESA Ministerial Commitment. This policy content analysis points towards the gaps we are still to meet within the universal health coverage agenda: better planning, prioritisation, sound policy frameworks and long-term commitments to meet the needs of adolescents.

INTRODUCTION
The WHO estimates that there were 21 million pregnancies among adolescents aged 15–19 years in 2019; 50% of these pregnancies were unintended.1 Fifty-five per cent of unintended pregnancies among adolescents aged 15–19 years often end in unsafe abortions, and adolescent mothers face higher risks of eclampsia and maternal mortality, and their infants are at risk of low birth weight.1

Adolescent pregnancy remains an alarming health and social problem in sub-Saharan Africa.2 Adolescent fertility rates (AFRs) continue to remain high, between 66.9 and 85.9 live births per 1000 adolescent girls aged 15–19 years, this policy content analysis provides insights into the prioritisation and integration of EUP within the latest national-level adolescent sexual and reproductive health and rights (ASRHR) policies.

The WHO recommends that sound policies should be evidence-based, include context-specific interventions, budgets to deliver the interventions and indicators to track progress.

The weaknesses identified across most policies in the ESA region are that there are no clear targets or interventions; these policies or strategies are not costed, nor are there any clear monitoring and evaluation indicators and frameworks in place.

In an era of growing global regress and the rollback of SRHR, with reduced funding towards abortion and punitive abortion laws, the gains made in countries such as Kenya with strong ASRHR policies are at risk; this is evident in Kenya’s failure to renew the ESA ministerial commitment. Addressing EUP and ASRHR requires long-term, sustained commitment, not a rollback on health rights and access to health services.

SUMMARY BOX
⇒ Adolescents are considered to be the missing population for the universal health coverage agenda. Early and unintended pregnancy (EUP) remains an alarming issue globally, with dire socioeconomic outcomes for adolescents, their offspring and society.
⇒ Given the magnitude of EUP in the Eastern and Southern Africa (ESA) region (66.9–85.9 live births per 1000 adolescent girls aged 15–19 years), this policy content analysis provides insights into the prioritisation and integration of EUP within the latest national-level adolescent sexual and reproductive health and rights (ASRHR) policies.
⇒ The WHO recommends that sound policies should be evidence-based, include context-specific interventions, budgets to deliver the interventions and indicators to track progress.
⇒ The weaknesses identified across most policies in the ESA region are that there are no clear targets or interventions; these policies or strategies are not costed, nor are there any clear monitoring and evaluation indicators and frameworks in place.
⇒ In an era of growing global regress and the rollback of SRHR, with reduced funding towards abortion and punitive abortion laws, the gains made in countries such as Kenya with strong ASRHR policies are at risk; this is evident in Kenya’s failure to renew the ESA ministerial commitment. Addressing EUP and ASRHR requires long-term, sustained commitment, not a rollback on health rights and access to health services.
is highest in lower-income and middle-income countries and low-income countries such as Angola (139), Zambia (112), the United Republic of Tanzania (112), the Democratic Republic of Congo (117), Malawi (130), Mozambique (138) and the Republic of Uganda (106). During the COVID-19 pandemic, there were increased levels of adolescent pregnancy due to the disruption of sexual and reproductive health and rights (SRHR) services and schooling. There are various drivers of adolescent pregnancy, such as limited contraceptive knowledge, limited access to contraceptives and other SRHR services, increased levels of violence, poverty, rural residence and child marriages.

In 2013, Ministers of Education and Health, through the ESA Ministerial Commitment, aimed to reduce early and unintended pregnancies (EUP) by 75% by 2020. The renewed ESA Commitment specifically, target six, aims to fast-track regional-level and country-level actions to reduce EUP among adolescents and young people aged 10–24 years by 40% by 2030. Given the magnitude of EUP in the ESA region and the global push towards universal health coverage (UHC), this analysis paper assesses the integration and prioritisation of EUP within national-level adolescent SRHR (ASRHR) policies and strategies in the ESA region.

**APPROACH TO POLICY ANALYSIS**

There are diverse perspectives on the elements of a policy analysis and the process for conducting a policy analysis. There is a broader focus in the literature on an analysis of the policy process involving the process of policy formulation and a power analysis of the actors involved. This policy analysis provides a review of EUP within current ASRHR policies, that is, a descriptive policy content analysis.

The scope, breadth and depth are wide for conducting a policy content analysis on EUP; this could include a focus on health, youth, education, gender, social protection and other interlinked policies such as reproductive health policies, child marriages and violence. There is a wide range of policies, but this study specifically narrowed its focus to assessing national-level ASRHR policies in the ESA region. A search for ASRHR policies (past 5–7 years, ie, 2015 onwards) was carried out for all countries in the region; only nine countries (Botswana, Kenya, Malawi, the Republic of Burundi, the Republic of Rwanda, South Africa, the United Republic of Tanzania, Zambia and Zimbabwe) that had policies that were either publicly accessible or recent (2015 onwards) were included in the study; all other countries in the region were not assessed due to either having an outdated policy or the policy is unavailable.

Each national-level ASRHR policy or strategy in each of the countries was mapped out in detail, with a focus on key terms such as ‘teenage pregnancy’, ‘pregnancy’, ‘fertility’, ‘AFR’ and ‘EUP’. WHO recommends that sound policies should be evidence-based, include context-specific interventions, budgets to deliver the interventions and indicators to track progress. In line with these recommendations, six key questions guided the analysis of each ASRHR policy in terms of EUP:

1. Who is the custodian of the policy (responsible ministry/ ministries)?
2. Does the policy specifically mention EUP or teenage pregnancy? If so, how, for example, are EUP, adolescent fertility or teenage pregnancy targets or specific interventions? How is EUP defined, that is, is there an explicit definition or conceptual framework provided?
3. Does the policy mention the reduction of EUP in line with the ESA target (75% by 2020 or 40% by 2030)? Is the policy aligned with any other regional instruments, for example, Southern African Development Community (SADC) and East African Community (EAC) progress indicators or scorecards?
4. Does the policy have any cost of interventions specific to EUP or teenage pregnancy? If so, specify the financial allocation.
5. Does the policy have any monitoring and evaluation framework of specific indicators to measure EUP?
6. Does the policy have any interventions linked to EUP/teenage pregnancy, for example, contraception, child marriages, prevention of HIV infections, gender-based violence (GBV and school re-entry)? If so, specify.

**ETHICAL CONSIDERATIONS, PATIENT AND PUBLIC INVOLVEMENT STATEMENT**

This policy analysis does not require ethical approval; it is based on policy documents and does not involve patients directly. Patient priorities, that is, adolescents’ health needs and challenges, serve as the rationale for conducting the study. Partnerships and consortiums, such as the Regional Inter-Agency Task Team for Children and AIDS in ESA and national-level governments, have prioritised tackling issues such as SRHR more broadly and EUP; patients (adolescents) are involved through various projects as youth activists as well as participating in consultative processes during policy development but are not directly involved in this study.

**ASRHR POLICY LANDSCAPE IN ESA**

An overview of EUP prioritisation and integration within the ASRHR policies within ESA is presented in Table 1. EUP is not a standalone ASRHR issue, and ASRHR policies (eg, Botswana, Malawi and South Africa) also focus on addressing the drivers of EUP, such as HIV prevention, violence, contraceptive use and school re-entry. Among the nine policies assessed, Kenya and Burundi set out a clear target of reducing EUP/adolescent pregnancy. Kenya, through the ASRH Policy 2015 and National ASRH Policy Implementation Framework, 2017–2021, set clear targets related to reducing teenage pregnancy according to a baseline of the 2015 Kenya Demographic and Health Survey (KDHS). Moroso, Kenya mentions alignment with the 2013 ESA Ministerial target to reduce EUP by 75% by...
Table 1 Assessment of EUP within ASRHR in Eastern and Southern Africa

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<tr>
<th>Country</th>
<th>Policy</th>
<th>Prioritisation of EUP</th>
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<tr>
<td>Botswana</td>
<td>Final Draft Botswana Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategy, 2018–2022</td>
<td>The policy recognises unintended pregnancy as an ASRHR problem and sets out an indicator (teenage pregnancy rate) and other related interventions, for example, family planning and strengthening AYFHS; however, interventions are not costed.11</td>
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<td>Kenya</td>
<td>National Adolescent Sexual and Reproductive Health Policy, 2015</td>
<td>The ASRHR policy recognises EUP as a priority and clearly outlines and costs of several interventions. Strategic area 5 of the policy focuses on reducing EUP. The interventions include male involvement and engagement in EUP, school re-entry and antenatal and postnatal maternal health services. The policy provides a baseline target based on the 2015 Kenya Demographic and Health Survey and sets targets for the reduction of teenage pregnancy. Kenya is the only country in the region to operationalise the ASRHR policy with an implementation framework. This framework proposes specific activities and costs at a national and country level on EUP.12 13</td>
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<tr>
<td>Malawi</td>
<td>National Youth Friendly Health Services Strategy, 2015–2020</td>
<td>This policy focuses on the improvement and scale-up of age-appropriate AFYHS and ASRHR services, such as CSE and contraception. The policy draws attention to EUP but does not have any indicators or costed interventions.14</td>
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<tr>
<td>Republic of Burundi</td>
<td>National Adolescent Health Strategy, 2015</td>
<td>The policy recognises EUP as a key ASRHR problem in the country and sets out targets linked to EUP, for example, the reduction of unwanted pregnancies among children aged 10–14 years by 80% by 2019.15 However, there are no costed interventions in the policy.</td>
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<td>Rwanda</td>
<td>National Family Planning and Adolescent Sexual and Reproductive Health Strategic Plan, 2018–2024</td>
<td>The Strategic Plan offers a description of the EUP and provides an overview of a range of ASRHR interventions, for example, a focus on quality ASRHR services through community health workers. The strategic plan sets out to cost each of these intervention areas 2018–2024, for example, the total allocation to objective 3 (improved availability of quality ASRH services) is close to US$9 million.16</td>
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<td>South Africa</td>
<td>National Adolescent and Youth Health Policy, 2017</td>
<td>The policy in South Africa highlights EUP as a priority; however, there are no clear targets or costed interventions. The policy does have a strong focus on improving AFYHS, contraception, school health programmes, violence and HIV. This policy is unique as it focuses on social protection, that is, the Child Support Grant, and a focus on addressing structural drivers of EUP, such as employment and economic empowerment strategies.17</td>
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<tr>
<td>United Republic of Tanzania</td>
<td>National Adolescent Health and Development Strategy, 2018–2022</td>
<td>EUP is recognised as a priority; however, there are no specific interventions, targets or costs. The policy does focus on other ASRHR issues, such as mainstreaming and improving AFYHS and other issues such as contraception and HIV.18</td>
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<tr>
<td>Zambia</td>
<td>Zambia Adolescent Health Strategy, 2017–2021</td>
<td>The policy does not have specific targets set for EUP. The policy specifies a costed intervention linked to EUP (two studies funded on adaptive leadership approaches for reducing teenage pregnancy and HIV prevalence). The policy proposes a 5-year budget of US$12 million for targeted districts in Zambia to scale up adolescent health service packages.19</td>
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<tr>
<td>Zimbabwe</td>
<td>National Adolescent and Youth Sexual and Reproductive Health Strategy II, 2016–2020</td>
<td>The strategy mentions EUP as an issue. There are no clear targets set or costed interventions. The strategy provides a focus on a range of ASRHR interventions, for example, HIV, CSE availability of quality ASRHR services and preventing stock-outs of medical commodities.20</td>
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ASRHR, adolescent sexual and reproductive health and rights policies; AYFHS, adolescent and youth-friendly health services; CSE, comprehensive sexuality education; EUP, early and unintended pregnancy.
the year 2020. However, it is important to note that Kenya has failed to renew its commitment to the ESA Ministerial Commitment. The Republic of Burundi clearly sets out to reduce EUP through the target indicator ‘reducing unwanted pregnancies among children aged 10–14years by 80% by 2019’.

South Africa’s National Adolescent and Youth Health Policy 2017 provides social protection support to young mothers through a Child Support Grant and has a focus on addressing the structural drivers of EUP through strategies and programmes geared towards the economic empowerment of adolescent girls and young women.

All the ASRHR policies assessed have a strong focus on improving the availability and quality of adolescent and youth-friendly health services (AYFHS). Zambia’s ASRHR policy proposes a 5-year budget of US$12 million for targeted districts in the country to scale up adolescent health service packages. In Rwanda, the National Family Planning and ASRH Strategic Plan, 2018–2024, objective 3 aims to improve the availability of quality ASRH services and proposes a US$9 million cost of this intervention area.

The main gap across most of these policies (besides Kenya) is that ASRHR policies do not have clear targets set for reducing EUP, and interventions are not costed. Kenya is considered to have the strongest policy in terms of EUP, for example, specific targets, intervention(s) and costing. Strategic area 5 of Kenya’s 2015 National Adolescent Sexual and Reproductive Health Policy focuses on EUP. The policy and strategic areas are informed through consultative processes with national-level and county-level stakeholders. Kenya is the only country in the ESA region that supplements its ASRHR policy with a detailed implementation framework—Kenya’s National Adolescent Sexual Reproductive Health Policy Implementation Framework, 2017–2021. The framework details specific intervention areas and targets, for example, promoting the provision of accurate information and services to prevent EUP, promoting school re-entry for mothers, and strengthening intersectoral coordination for effective prevention of EUP. The EUP programme costs between US$4 million and US$7 million on a yearly basis.

While national-level ASRHR policies across the ESA region do prioritise and recognise EUP, there is also a focus on interlinked interventions such as CSE, violence and family planning. These national-level strategies and policies do not go far enough in terms of clear target setting, clearly defined interventions, costing, monitoring and evaluation frameworks. Several ASRHR policies in the ESA region are not publicly accessible or outdated. Governments need to ensure that ASRHR policies are accessible and that policies are renewed on a regular basis, for example, over a 5-year time period. The policy framework affects the implementation and resource mobilisation efforts; governments need to ensure sound priority-setting, policymaking and planning according to the WHO recommendation—inclu- sion of context-specific interventions, budgets to deliver the interventions and indicators to track progress for EUP policies in the region. For national-level policies to be implementable and to monitor progress, governments need to set EUP targets in ASRHR policies; interventions need to be outlined, and these interventions need to be costed.

In changing contexts, such as the growing regress on SRHR, abortion rights and the rights of women and girls, it is important to make long-term commitments. The 2022 KDHS indicates a 3% decline; 15% of adolescents aged 15–19 years were found to be pregnant, and the ASRHR policies and implementation frameworks are strong; however, Kenya has reneged on its commitment to the regional ESA Ministerial Commitment, which prioritises various elements of ASRHR, including EUP. Strong policy and implementation frameworks remain important, but they are one part of tackling EUP; this is needed within the legislation, across sectors (eg, education, social development, youth development and health) and at the service delivery level. This policy content analysis points to the need and importance of clear priority-setting and planning for ASRHR issues such as EUP. Without this strong framework, there is minimal guidance for the implementation and resource mobilisation agenda, and adolescent issues will remain neglected within the UHC and health systems.

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