“Granny at 27”: A Scoping Study of Adolescent Sexual and Reproductive Health Stigma and School Re-Entry for Adolescent Mothers in Kenya

By April Cheng
Faculty mentor : Dr. Emma Smith
Georgetown University

Acknowledgement

I gratefully appreciate **Professor Smith** for the mentorship, **Gui2de** for the research internship, **Laidlaw Scholars Foundation** for the funding, and local partner **Ipas** and **CEFERD** for coordinating the field work. Without the patience and passion that everyone I encountered has given me to learn about adolescent sexual and reproductive health in Kenya, I would never have been able to produce this report. I am deeply thankful for this incredible journey and everyone that supported me through it.

Methodology

The research combined a **literature review**, **stakeholder interviews** in Nairobi (n=15), **data from pilot** that was conducted in December 2025 (n=123) **field visits in health clinics** (n=3), and **focus group discussions** with adolescents aged 10–18 (n=89) in Kisumu and Vihiga Counties.

Introduction

ASRH remains a significant public health challenge in Kenya. **Over 19% of women aged 15–24 reported having sex before age 15, and 15% had experienced at least one pregnancy**, according to the 2022 Kenya Demographic and Health Survey (Kenya National Bureau of Statistics & ICF, 2023). Despite progress in reducing teenage pregnancy over the past decade, **the rate rose 2.2% between 2024 and 2025, with the steepest increase among girls aged 10–14** (BMC Women's Health, 2022). Economic deprivation, early sexual debut, entrenched stigma, and persistent barriers to youth-friendly healthcare all contribute to this trend (Sidamo et al., 2023). While Values Clarification for Action and Transformation(VCAT) workshops have demonstrated success in reducing provider stigma within abortion care, **evidence for their effectiveness across the broader adolescent sexual and reproductive health (ASRH) context remains limited** (Wollum et al., 2025).. This project explores the factors influencing adolescents' access to sexual and reproductive health (SRH) services and school drop-outs for adolescent mothers. My primary contribution is **developing a Theory of Change and for a future cluster-randomized controlled trial led by Gui2de.**

Figure I:
Location of the project counties in Kenya

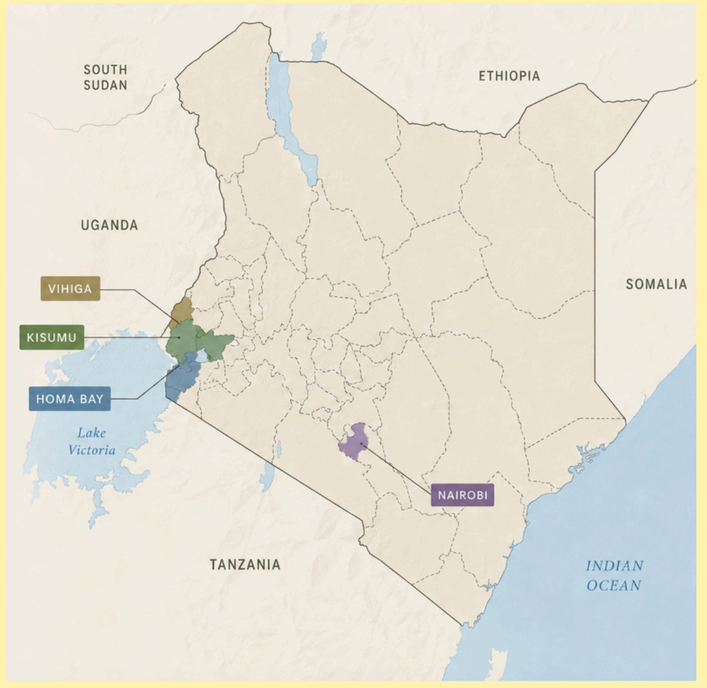
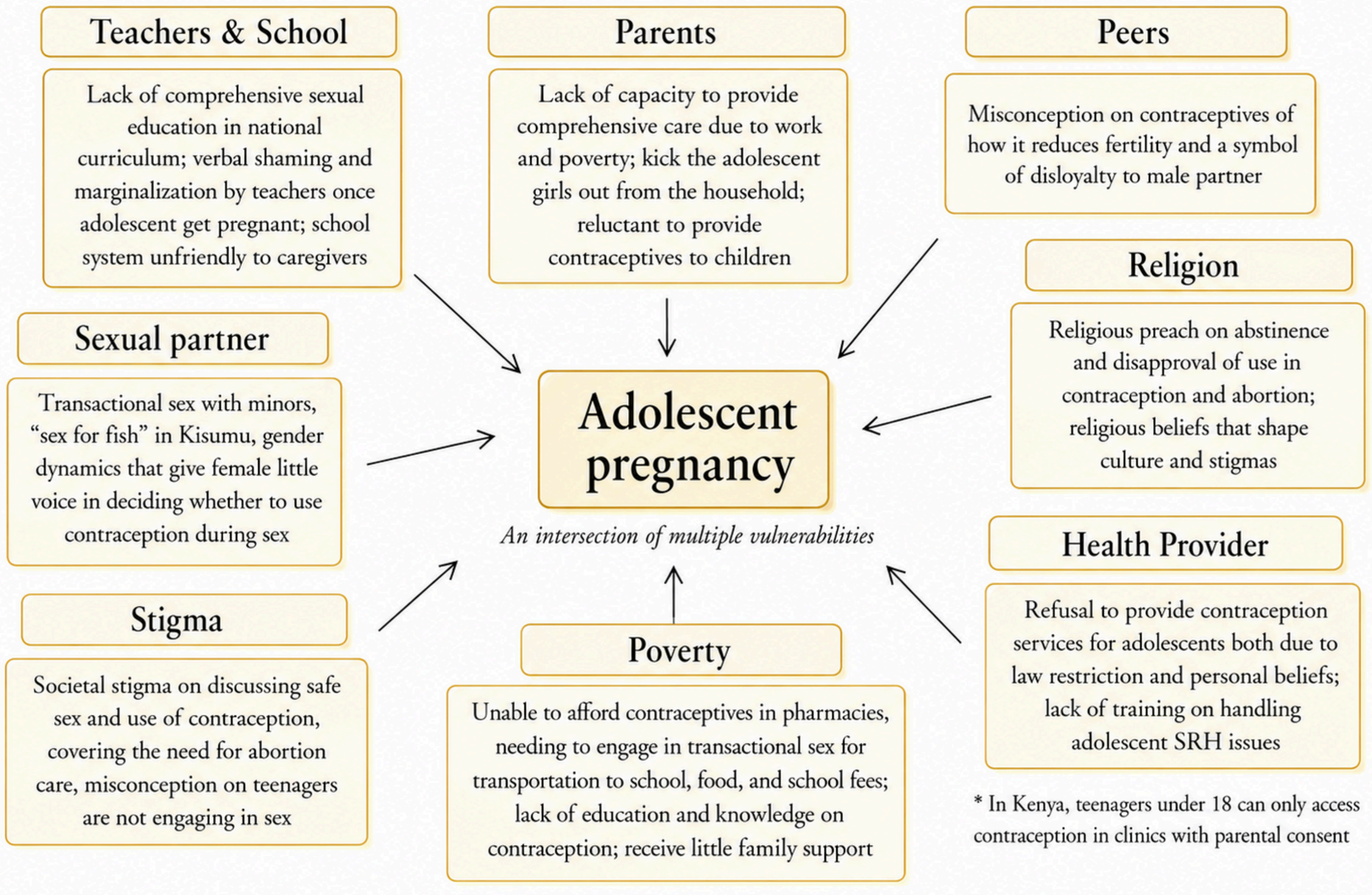


Figure II:
Relational graph for the causes to adolescent pregnancy



RESULTS

While Figure II summarizes the multiple drivers of adolescent pregnancy that were agreed among the stakeholders, interviews revealed **important disagreements regarding which barriers are most consequential**. The largest divergence concerned healthcare providers: NGO staff and adolescents frequently described judgmental attitudes, confidentiality breaches, and reluctance to provide contraception to unmarried adolescents, whereas government providers reported that these practices have largely diminished following VCAT training. Stakeholders also **disagreed on whether current barriers to contraceptive access primarily reflect provider stigma, commodity shortages following recent USAID funding reductions, or legal uncertainty surrounding adolescent consent policies**. These contrasting perspectives underscore the importance of measuring provider behavior alongside provider attitudes.

Although Kenya's School Re-Entry Guidelines protect pregnant learners' right to continue their education, respondents consistently reported **uneven implementation and persistent stigma from teachers and peers that discourages school retention.** Family support emerged as the strongest facilitator of school re-entry, while stakeholders emphasized that improving adolescent outcomes requires coordinated action across households, schools, health facilities, and communities **rather than isolated interventions.**

Priotization

1. **School interventions**: train teachers and accountability system for re-entry policy and collection of data on school drop-out due to pregnancy.
2. **Destigmatization**: research on how to conduct effective group-destigmatization interventions.
3. **Synthesize resources:** combine existing resource and funding to map out the ecosystem contributing to adolescent pregnancy and invest through collective action.
4. **Support CBOs**: invest in community-based organization to empower existing local infrastructure to adopt intervention into local context.

Discussion

1. **Abortion care:** abortion remains among the most politically sensitive areas of SRH programming in Kenya and comparatively few organizations engage with it directly even as they support contraception, education, and economic empowerment. Future programming and research should more directly incorporate adolescents' reproductive autonomy and agency into program design, rather than framing adolescent SRH solely in terms of pregnancy prevention.
2. **NGO fragmentation:** multiple organizations frequently deliver near-identical programming within the same communities under different funding streams, a pattern that two NGO staff attributed to donor incentives favoring individually demonstrable impact over collaboration.

> *“we are a very religious country, even though we try to hide but it underlies every issue.”*

> *“the teacher forced me to drop out.”*