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

Student: April Cheng

Institution: Georgetown University

Mentor: Dr. Emma Smith

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Abstract

Adolescent pregnancy in Kenya has risen for two consecutive years, with the sharpest increase among girls aged 10–14 (Kenya National Bureau of Statistics, 2022). This report presents findings from a scoping phase of research supporting the development of an expanded Values Clarification and Attitude Transformation (VCAT) intervention targeting healthcare providers and community health promoters in Kisumu and Vihiga counties, Kenya. Drawing on pilot data (n=123) understanding that was done in December 2025, the report further conducted 15 stakeholder interviews, 3 adolescent focus group discussions (n=89), and a review of literature in adolescent sexual and reproductive health (ASRH). This report identifies the socioeconomic, institutional, and normative drivers of adolescent pregnancy and school dropout, and develops a preliminary theory of change to guide a future cluster-randomized controlled trial. Findings point to parental engagement, poverty, contraceptive stigma, and inconsistent implementation of school re-entry policy as central and interacting barriers, while stakeholders diverge over whether provider stigma persists, whether contraceptive access is limited by supply or demand, and how legal ambiguity shapes provider behavior. The report concludes that fragmentation across implementing organizations is among the most significant barriers to progress, and that abortion and post-abortion care remain an underaddressed priority within the broader ASRH agenda.

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 VCAT workshops have demonstrated success in reducing provider stigma within abortion care, evidence for their effectiveness across the broader ASRH context remains limited (Wollum et al., 2025).

This project contributes to the development and evaluation of an expanded VCAT intervention targeting healthcare providers and community health promoters in Kisumu and Vihiga counties. Following a pilot conducted in December 2025 by CEFERD in collaboration with Georgetown University in Homa Bay County (n=123), this research undertook further scoping work to understand the stakeholders and mechanisms driving Kenya's rising adolescent pregnancy rate. My specific contribution was to develop the project's theory of change and pre-analysis plan for a future cluster-randomized controlled trial to be conducted by Gui2de, evaluating impacts on adolescent pregnancy, school retention, healthcare utilization, and provider practice in Kisumu County. Through literature review, stakeholder interviews, field observations, and focus group discussions with youth, I sought to identify the mechanisms through which provider attitudes influence service delivery behaviors and adolescent outcomes.

Methodology

This report draws on four sources of evidence: stakeholder interviews, forum discussions on adolescent health, a review of relevant literature, and field observations in clinics and adolescent focus groups. Prior to fieldwork, I conducted a desk review of academic literature and project materials on the relationship between provider behavior and ASRH stigma, and analyzed pilot data collected to develop preliminary hypotheses and an initial theory of change linking provider attitudes to adolescent outcomes. Fieldwork was conducted across Nairobi, Kisumu, and Vihiga County and included both national- and community-level stakeholders. In Nairobi, I interviewed NGO staff, researchers, and practitioners working on ASRH policy and program implementation (n=16). In Kisumu and Vihiga County, I collaboratively conducted three focus group discussions with adolescents aged 10–18 (n=89) and observed youth-friendly service training at health facilities led by a local implementing organization. Analysis focused on identifying recurring themes, points of disagreement, gaps between literature and NGO practice, and emerging research priorities, organized around two central themes: stigma surrounding ASRH, and school dropout and re-entry among adolescent mothers.

Findings

I. ASRH Stigma

Across nearly all interviews, adolescent pregnancy was described as a multifaceted issue shaped by overlapping socioeconomic factors rather than a single cause. Parents emerged as central but underutilized actors: stakeholders identified parental support as one of the strongest determinants of whether adolescents receive accurate information, seek reproductive health services, or continue schooling after pregnancy, yet parents themselves often lack accurate knowledge of contraception or feel uncomfortable discussing sexuality with their children. Few interventions have historically engaged parents directly, though organizations such as CARE International's SHE SOARS program have begun promoting intergenerational dialogue to normalize household conversations about sexual health (CARE Canada, 2021).

Poverty continues to underpin adolescent pregnancy. Participants described adolescent girls engaging in transactional relationships with fishermen, boda boda riders, farmers, and other older men in exchange for transport, food, or financial support — with local NGO workers specifically dismissing the popular narrative that boda boda riders are the primary perpetrators, instead identifying farmers, fishermen, and adolescent boys as the main actors. Several organizations noted that reductions in international donor funding have disproportionately affected the most vulnerable groups. While cash transfer programs remain the most intuitive response to poverty-driven pregnancy, existing evidence on their effectiveness remains inconclusive (Azumah et al, 2022), and relatively few programs beyond PEPFAR's DREAMS initiative provide direct economic support such as scholarships or school supplies in Western Kenya.

Stigma surrounding contraception remains widespread, with organizations describing persistent misconceptions that contraceptives cause infertility or are appropriate only after marriage or childbirth. One adolescent focus group participant stated that contraceptives "should not be given to teens because they will be misused anyway," and respondents described decision-making around contraception as frequently controlled by male partners, with female use sometimes read as a sign of infidelity. Comprehensive Sexual Education (CSE) remains excluded from Kenya's formal national curriculum, though respondents noted growing community-based SRH education led by the Ministry of Health and, notably, by faith-based organizations — with less religious or community opposition than anticipated (Sidze et al., 2017). Nonetheless, it is important to note the CSE that is accepted by the religious institutions and community might be different from the CSE that is effective in reducing teenage pregnancy.

However, the definition of what encompasses CSE could be different across stakeholders. According to the interview from a development policy research institution, the religion element that is driving the stigma. The researcher mentioned that “we are a very religious country, even

though we try to hide but it underlies every issue." The relevant research also shows religion playing a big role in contraception use, and Muslim having significantly less uptake of contraception use compared to Christians in Kenya. (Speizer et al., 2025) Though the churches and other religious leaders might have been implementers for CSE, their approach mainly still focuses on abstinence rather than education about safe sex and contraception. In addition, religious groups have been one of the biggest pushers for implementing CSE in national education from the policy and law perspective as well. Though there has been consistent training and collaboration on religious leaders on CSE, it seems to have limited results in fundamentally shaping what they believe as indicated by the researcher. Though there is some literature that shows the potential in engaging religious leaders to increase the use of family planning services, the current interventions by NGOs neglect the intervention of religious leaders (Ruark et al., 2019).

Stakeholders diverged on several points. First, while nearly every NGO worker described provider attitudes as a major barrier — citing refusals to provide contraception to unmarried or "too young" adolescents, breaches of confidentiality, and stigmatizing remarks — yet government healthcare workers in Kisumu reported that mistreatment "barely exists" now that providers have received VCAT training. This divergence between provider self-assessment and the accounts of adolescents and NGO workers represents a central open question for the intervention. On the VCAT effectiveness, compared with the pilot data that was conducted in December 2025, the health providers on the ground seem to hold a uniformly more positive attitude to VCAT. From the pilot data, it indicated that healthcare workers with more favorable SRH attitudes are more likely to perceive VCAT as effective ($n=123$, $p < 0.02$), yet from the qualitative interviews, everyone has perceived VCAT as an effective measurement to improve health providers' attitude.

Second, stakeholders disagreed on whether the primary barrier to contraceptive access is misinformation and stigma or physical shortages of commodities linked to recent USAID funding reductions; these contrasting views likely reflect differences between national-level distribution data and local implementation realities. Third, some attributed provider reluctance purely to community stigma, while others pointed to legal ambiguity: Kenya's 2015 National Adolescent SRH Policy had moved to remove consent requirements for under-18 adolescents seeking contraceptives, but the 2022–2032 National Reproductive Health Policy reversed this provision amid rising opposition from anti-rights groups, leaving providers uncertain about their legal liability independent of personal belief (Making Waves Network, 2022). Finally, several stakeholders identified local chiefs as an underexplored but potentially valuable resource for identifying vulnerable adolescents and coordinating referrals, though chief engagement varies considerably by county and is not uniformly recognized by stakeholders.

II. Adolescent pregnancy and school drop out

A 2025 public health study in western Kenya found that 34.6% of girls dropped out during primary education, with pregnancy, early marriage, and childcare responsibilities accounting for over 40% of dropouts (Center for Reproductive Rights, 2026). Family support emerged as one of the strongest determinants of school re-entry: stakeholders described cases in which parents withdrew financial assistance or redirected resources toward other children, leaving adolescent mothers to raise children independently. One adolescent mother recalled that she "was only able to return to school because my mother took care of the baby at home." A cross-sectional study in Siaya County similarly found that pregnancy and childcare needs accounted for 42.5% of reported dropout reasons, more than double the next most common cause (Nungo et al., 2025).

School-based stigma also emerged as a near-universal concern. Although Kenya's 2020 School Re-Entry Guidelines formally guarantee pregnant girls the right to remain in or return to school, respondents repeatedly described inconsistent implementation, including ridicule and discrimination from teachers and peers that led many girls to leave voluntarily even without formal expulsion (Kenya Ministry of Education, 2020). One adolescent from the focused group summarized her experience by stating that "the teacher forced me to drop out." Another policy researcher recounted in schools the teachers will call teenage girls as “mama” to distinguish them from their peers and make comments such as “you are someone’s parent, you should be working even harder.” Yet, the same judgement seems to be mainly imposed on women but not the father of the child who is in the same age group or even the same school. Stakeholders differed on the underlying cause: some argued that Kenya already possesses an adequate policy framework and that the core problem is weak accountability for teachers, while others maintained that even perfect implementation would not resolve household- and community-level stigma that independently drives dropout. Most ultimately converged on the view that improving retention requires coordinated action across schools, households, health systems, and communities rather than a single-sector fix. In addition, one of the evidence gaps and missing data remains the school drop-out that is due to teenage pregnancy. Though there are rates of adolescent pregnancy and school drop-out separately, the existing data on how percentage of girls are dropping out because of pregnancy remains absent.

Theory of Change

The dominant theory of change emerging from this research holds that neither ASRH stigma nor school dropout can be addressed through isolated interventions. For stigma reduction, stakeholders emphasized sustained, multi-stakeholder community dialogue — involving adolescents, parents, teachers, providers, and religious leaders — over one-off information campaigns, while acknowledging that changing deeply rooted beliefs remains slow and uncertain in duration and intensity (Robin et al., 2004). Youth-friendly health centers were broadly viewed as a valuable but geographically limited resource, concentrated in hospitals and largely inaccessible in peri-urban areas (Embleton et al., 2024).

For school retention, economic empowerment and community-based coordination emerged as the most consistently cited pathways. Community-based organizations such as Bumulusi in Vihiga, which coordinates referrals across health facilities, schools, churches, and families, were repeatedly highlighted as models of an ecosystem-based approach grounded in local cultural context (Ochunge, 2023). Stakeholders argued that national policy provides an essential framework, but that local organizations are better positioned to adapt implementation to county-specific realities — a view echoed by government-affiliated actors who pointed to grassroots organizations such as Dreams Redefined as examples of ground-up SRH service delivery in Kisumu (Dreamsgirlzyouth.org, 2017). This view is also reinforced by the pilot data evidence. From the pilot data, healthcare workers with more favorable SRH attitudes are also more likely to view structured youth environments such as after-school clubs effective interventions ($n=122$, $p<0.001$). In other words, the healthcare providers have a more positive SRH attitude and also consider school as an overall important element to improve ASRH.

Discussion

This research suggests that adolescent pregnancy in Kenya reflects the interaction of multiple systems — families, schools, healthcare institutions, and economic structures — rather than a single point of failure. One encouraging finding was the continued evolution of Kenya's policy environment, including growing Ministry of Education attention to teenage dropout through a dedicated technical working group. However, a significant and recurring barrier is the fragmentation of current interventions: 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. As USAID funding has receded and financing has shifted toward county governments, the coordinating role of county government becomes correspondingly more important. Especially on the topic of shifting stigma on SRH, the continuation of intervention and programming is particularly important in changing the social norm on how people perceive SRH-related services from contraception to abortion care. Though the existing literature often emphasizes shifting the belief of individual stigmatizers, there seems to be limited research on

how to shift stigma in a community as a whole. Though there's research conducted on the reduction of structural and public forms of stigma norm of HIV/AIDS in the United States, evidence coming from the global south on destigmatization for global health remains limited (Claire et al., 2016)

A further gap concerns abortion and post-abortion care, which received comparatively little attention across interviews despite several NGO workers identifying unsafe abortion as their original motivation for entering ASRH work. Abortion remains among the most politically sensitive areas of SRH programming in Kenya, particularly amid a rising anti-rights movement, 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.

Conclusion

This qualitative scoping research demonstrates that stakeholders across Kenya largely share a common understanding of adolescent pregnancy as a multidimensional challenge requiring coordinated responses across families, schools, healthcare systems, and communities. Greater parental engagement, stronger teacher accountability, expanded psychosocial support, improved inter-organizational coordination, and increased investment in community-based organizations were repeatedly identified as priorities for future programming. These findings inform a preliminary theory of change and pre-analysis plan for a future cluster-randomized controlled trial evaluating an expanded VCAT intervention in Kisumu County. Ultimately, reducing adolescent pregnancy and supporting pregnant adolescents to remain in school will require strengthening the broader ecosystem in which adolescents live, learn, seek healthcare, and make decisions — not simply expanding any single service in isolation.

References

Azumah, C., et al. (2022). *Child pregnancy prevention in Kenya: Rapid review of the literature.* IDinsight.https://www.idinsight.org/wp-content/uploads/2022/03/NGEC-Literature-Review_-Child-Pregnancy-Prevention-Report_final-version-.pdf

Birdthistle, I., Kwaro, D., Shahmanesh, M., Baisley, K., Khagayi, S., Chimbindi, N., ... & Floyd, S. (2021). Evaluating the impact of DREAMS on HIV incidence among adolescent girls and young women: A population-based cohort study in Kenya and South Africa. *PLoS Medicine, 18*(10), e1003837.

CARE Canada. (2021, October 26). *SHE SOARS – Kenya, Uganda, Zambia.* care.ca/projects/she-soars/

Center for Reproductive Rights. (2026, April 23). *Kenya strengthens school re-entry protections for pregnant learners and adolescent mothers.* reproductiverights.org/news/kenya-strengthens-school-re-entry-protections-pregnant-learners-adolescent-mothers/

Chandra-Mouli, V., Lane, C., & Wong, S. (2015). What does not work in adolescent sexual and reproductive health: A review of evidence on interventions commonly accepted as best practices. *Global Health: Science and Practice, 3*(3), 333–340.

Chimbindi, N., Birdthistle, I., Shahmanesh, M., Osindo, J., Mushati, P., Ondeng'e, K., ... & Seeley, J. (2018). Translating DREAMS into practice: Early lessons from implementation in six settings. *PLoS ONE, 13*(12), e0208243.

Clair, M., Daniel, C., & Lamont, M. (2016). Destigmatization and health: Cultural constructions and the long-term reduction of stigma. Social science & medicine, 165, 223-232.

Daniel, A. K., Casmir, E., Oluoch, L., et al. (2023). "I was just concerned about getting pregnant": Attitudes toward pregnancy and contraceptive use among adolescent girls and young women in Thika, Kenya. *BMC Pregnancy and Childbirth, 23*(1), 493.

Dreamsgirlzyouth.org. (2017). *Dreams Redefined CBO.* https://www.dreamsgirlzyouth.org/

Embleton, L., Boal, A., Sawarkar, S., Chory, A., Bandanapudi, R. M., Patel, T., Levinson, C., Vreeman, R., Wu, W.-J., Diaz, A., & Ott, M. A. (2024). Characterizing models of adolescent and youth-friendly health services in sub-Saharan Africa: A scoping review. *International Journal of Adolescent Medicine and Health, 36*(3), 203–236.

Erulkar, A. S., Mekbib, T. A., Simie, N., & Gulema, T. (2006). Differential use of adolescent reproductive health programs in Addis Ababa, Ethiopia. *Journal of Adolescent Health, 38*(3), 253–260.

Gichuki, Lydia. “Kenya’s 2024 Humanitarian Aid Landscape: Impact of US 90-Day Aid Suspension.” DevelopmentAid, 30 Jan. 2025,

https://www.developmentaid.org/news-stream/post/190784/impact-of-us-90-day-aid-suspension-on-kenya. Accessed 16 July 2026.

Icsafrica-Sp.org. (2025). *Inclusive education and life skills.* https://www.icsafrica-sp.org/areas-of-work/inclusive-education-and-life-skills/

Jonas, K., Crutzen, R., Van Den Borne, B., & Reddy, P. (2017). Healthcare workers' behaviors and personal determinants associated with providing adequate sexual and reproductive healthcare services in sub-Saharan Africa: A systematic review. *BMC Pregnancy and Childbirth, 17*(1), 86.

Kenya Ministry of Education. (2020). *National guidelines for school re-entry in early learning and basic education.*

Kenya National Bureau of Statistics. (2026). *Economic survey 2026.* https://www.knbs.or.ke/wp-content/uploads/2026/04/2026-Economic-Survey.pdf

Kenya National Bureau of Statistics & ICF. (2023). *Kenya Demographic and Health Survey 2022.* KNBS and ICF.

Kinaro, J. W., Wangalwa, G., Karanja, S., Adika, B., Lengewa, C., & Masitsa, P. (2019). Socio-cultural barriers influencing utilization of sexual and reproductive health (SRH) information and services among adolescents and youth 10–24 years in pastoral communities in Kenya. *Advances in Sexual Medicine, 9*(1), 1–16.

Kisumu Medical and Education Trust. (2026). *Young people's health and empowerment.* https://kmet.co.ke/programs/young-peoples-health-empowerment/

Kumar, M., Huang, K. Y., Othieno, C., Wamalwa, D., Madeghe, B., Osok, J., et al. (2018). Adolescent pregnancy and challenges in Kenyan context: Perspectives from multiple community stakeholders. *Global Social Welfare, 5*(1), 11–27.

Makenzius, M., Rehnström Loi, U., Otieno, B., & Oguttu, M. (2023). A stigma-reduction intervention targeting abortion and contraceptive use among adolescents in Kisumu County, Kenya: a quasi-experimental study*. Sexual and Reproductive Health Matters, 31(1). https://doi.org/10.1080/26410397.2021.1881208

Making Waves Network. (2022, August 5). *Kenya's new National Reproductive Health Policy 2022–2032.* makingwaves.network/2022/08/05/kenyas-new-national-reproductive-health-policy-2022-2032/

Mulwa, S., Chimoyi, L., Agbla, S., Osindo, J., Wambiya, E. O., Gourlay, A., ... & Floyd, S. (2021). Impact of the DREAMS interventions on educational attainment among adolescent girls and young women: Causal analysis of a prospective cohort in urban Kenya. *PLoS ONE, 16*(8), e0255165.

Mutea, L., Ontiri, S., Kadiri, F., Michielesen, K., & Gichangi, P. (2020). Access to information and use of adolescent sexual reproductive health services: Qualitative exploration of barriers and

facilitators in Kisumu and Kakamega, Kenya (M. T. Baysari, Ed.). *PLOS ONE, 15*(11), e0241985.

Mwaisaka, J., Wado, Y. D., Ouedraogo, R., et al. (2021). "Those are things for married people": Exploring parents'/adults' and adolescents' perspectives on contraceptives in Narok and Homa Bay Counties, Kenya. *Reproductive Health, 18*(1), 48.

Nungo, S., et al. (2025). Factors associated with school dropout and sexual and reproductive health: A cross-sectional analysis among out-of-school girls in western Kenya. *BMJ Public Health, 3*(1).

Obiezu-Umeh, C., Nwaozuru, U., Mason, S., Gbaja-Biamila, T., Oladele, D., Ezechi, O., & Iwelunmor, J. (2021). Implementation strategies to enhance youth-friendly sexual and reproductive health services in sub-Saharan Africa: A systematic review. *Frontiers in Reproductive Health, 3*, 684081.

Ochunge, N. (2023, October 22). Meet the rural champions helping women combat unsafe abortion. *The Standard.* www.standardmedia.co.ke/health/reproductive-health/article/2001483907/meet-the-rural-champions-helping-women-combat-unsafe-abortion

Orawo, P., & Nyandat, C. (2018, January 17). *Using grassroots advocacy to increase utilization and access to youth friendly services: The KMET experience.* SSRN. https://dx.doi.org/10.2139/ssrn.3103925

Robin, L., Dittus, P., Whitaker, D., Crosby, R., Ethier, K., Mezoff, J., et al. (2004). Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: A decade in review. *Journal of Adolescent Health, 34*(1), 3–26.

Ruark, A., Kishoyian, J., Bormet, M., & Huber, D. (2019). Increasing family planning access in Kenya through engagement of faith-based health facilities, religious leaders, and community health volunteers. Global Health: Science and Practice, 7(3), 478-490.

Sidamo, N. B., Kerbo, A. A., Gidebo, K. D., & Wado, Y. D. (2023). Socio-ecological analysis of barriers to access and utilization of adolescent sexual and reproductive health services in sub-Saharan Africa: A qualitative systematic review. *Open Access Journal of Contraception, 14*, 103–118.

Sidze, E. M., Stillman, M., Keogh, S., Mulupi, S., Egesa, C. P., Leong, E., et al. (2017). *From paper to practice: Sexuality education policies and their implementation in Kenya.* Guttmacher Institute.

Speizer, I. S., Bazie, F., Maytan-Joneydi, A., Mushomi, J. A., Chaibou, S., Boukary, K., ... & Rwenyo, J. (2025). Examination of adolescent and youth modern contraceptive users' perceptions on how religion influences contraceptive use and their rationale and circumstances of use: qualitative evidence from Burkina Faso, Kenya and Niger. Journal of Population Research, 42(1), 9.

Thirugnanasampanthar, S. S., Embleton, L., Di Ruggiero, E., Braitstein, P., Oduor, C., & Dibaba Wado, Y. (2023). School attendance and sexual and reproductive health outcomes among adolescent girls in Kenya: A cross-sectional analysis. *Reproductive Health, 20*(1), 29.

Trends and determinants of adolescent pregnancy: Results from Kenya Demographic Health Surveys 2003–2014. (2022). *BMC Women's Health, 22*, 416.

Wollum, A., Key, K., Mersha, T., Nicholson, M., Page, G., Austen, K., et al. (2025). Does a values clarification and attitudes transformation (VCAT) workshop influence provider attitudes, knowledge, and service provision related to abortion care? Evidence from a mixed-methods longitudinal randomised controlled trial in Ethiopia. *Global Public Health, 20*(1).