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Evidence Brief

Reducing adolescent pregnancy in Kenya

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Key messages

- The adolescent birth rate in Kenya remains high, with 15% of girls aged 15–19 years having begun childbearing (KDHS, 2022).
- Counties such as Samburu (50%) and West Pokot (36%) report the highest rates of teenage pregnancy.
- Adolescents face sexual and reproductive health (SRH) challenges due to poverty, lack of education, harmful cultural practices, and weak legal enforcement.
- Evidence shows that school-based SRH education, peer-led interventions, and integrated youth-friendly services reduce teenage pregnancy.
- Social norms, parental engagement, and economic empowerment have a significant influence on adolescent reproductive choices.

Executive summary

Adolescent pregnancy remains a critical public health and development challenge in Kenya, with significant health, social, and economic consequences for girls, their families, and the nation. Despite ongoing efforts, adolescent pregnancy rates in Kenya remain high, particularly in marginalised counties, posing a threat to national goals on health, education, gender equality, and socio-economic development.

This evidence brief synthesises findings from 15 peer-reviewed studies conducted in Kenya and other low- and middle-income countries (LMICs) to identify actionable interventions for reducing adolescent pregnancy. The evidence highlights a complex interplay of factors, ranging from poverty, harmful social norms, and weak enforcement of protective laws, to gaps in access to youth-friendly sexual and reproductive health (SRH) services and comprehensive sexuality education.

Key strategies identified include strengthening enforcement of child protection and gender-based violence laws, scaling up social and behavioural change communication (SBCC) to address harmful norms and stigma, expanding adolescent-responsive SRH services within communities and health facilities, and enhancing school- and community-based sexuality education. Parental engagement, economic empowerment of girls, and meaningful involvement of adolescents in programme design also emerged as critical factors for success.

Background

Adolescent pregnancy is a global phenomenon with profound health, social, and economic consequences. Globally, approximately 21 million girls aged 15–19 years in LMICs become pregnant each year, and about 12 million give birth [1]. Early childbearing is associated with increased risks of maternal and neonatal complications, school dropout, gender-based violence, and lifelong poverty. The burden is particularly acute in Sub-Saharan Africa, where adolescent birth rates remain among the highest worldwide, including among girls aged 10 - 14 years (4.4 per 1,000).

In Kenya, adolescents aged 10–19 years make up nearly 23% of the population (KNBS, 2019). Despite a national decline in the teenage pregnancy rate from 18% in 2014 to 15% in 2022 [2], some counties, including Samburu (50%) and West Pokot (36%), still report alarmingly high rates. Adolescent girls in these regions are disproportionately affected by poverty, low school retention, early marriage, lack of SRH knowledge, limited access to youth-friendly services, and harmful cultural norms, including female genital mutilation (FGM) and child marriage.

Education is one of the strongest protective factors against early pregnancy. However, many girls in Kenya miss school due to menstruation, lack of sanitary products, or early caregiving responsibilities. According to the KDHS 2022, adolescent girls aged 15–19 with no education are around eight times more likely to have ever been pregnant compared to those with more than secondary education [2]. Moreover, societal stigma and weak policy enforcement further compromise the ability of adolescent girls to access preventive health care, exercise reproductive autonomy, and remain in school.

Kenya has recognised these challenges through national policy frameworks such as the Reproductive Health Policy for 2023-2032 [3]and the National School Health Policy (2018) [4], both emphasising multisectoral action, age-appropriate comprehensive sexuality education, and adolescent-friendly services. However, persistent policy-practice gaps and inconsistent implementation have constrained their impact, particularly in underserved counties. Joanna et al. (2016) emphasised the health risks associated with unintended adolescent pregnancies. UNFPA (2022) and WHO (2024) provide global context and reinforce the urgency of policy and programmatic responses for preventing adolescent pregnancy tailored to LMICs such as Kenya.

These realities highlight the urgent need for evidence-informed interventions that go beyond policy rhetoric to address structural inequities, harmful social norms, service delivery gaps, and enforcement failures. A comprehensive, context-sensitive response is required, one that empowers adolescents with knowledge, ensures access to quality SRH services, strengthens legal protections, and fosters supportive community and school environments. This evidence brief seeks to inform such a response by synthesising research on proven and promising strategies for preventing adolescent pregnancy in Kenya.

Methodology

This evidence brief is based on a rapid evidence synthesis conducted to identify effective interventions for preventing adolescent pregnancy in Kenya and comparable LMIC settings. A structured search of peer-reviewed and grey literature was performed using databases such as PubMed, Google Scholar, and institutional repositories. The search focused on studies published between 2010 and 2024 to capture recent evidence and emerging interventions. The initial search yielded 33 studies, of which 17 met the inclusion criteria. Of these, 6 were from Kenya, while 11 were from other Sub-Saharan African LMICs. Studies were included if they focused on adolescents aged 10–19 years and addressed issues related to preventing adolescent pregnancy, access to sexual and reproductive health (SRH) information and services, school-based or community-based sexuality education, social and behavioral change communication, enforcement of protective laws, or the influence of parents, peers, and community norms on adolescent reproductive choices.

Eligible studies were conducted in LMICs, prioritised sub-Saharan Africa, and employed quantitative, qualitative, mixed-methods research that reported relevant evidence. Data extraction was performed using a standardised tool to capture key study characteristics, intervention details, main findings, and their relevance to adolescent pregnancy prevention. Findings were then analyzed thematically and synthesised narratively to generate practical recommendations aligned with Kenya's policy priorities and programmatic needs.

Key findings

Findings from the reviewed studies bring out the complex interplay between structural, behavioral, educational, and health system factors contributing to adolescent pregnancy. Enforcement of legal protections remains weak in many counties across Kenya and other LMICs. Harada et al. (2024) highlight how cultural taboos and misinformation hinder adolescent access to SRH services, suggesting a disconnect between national SRH policies and their practical implementation. Meanwhile, UNFPA (2022) reports that enforcement of laws related to child marriage, gender-based violence, and FGM remains weak across many LMICs, including Kenya, calling for more robust accountability mechanisms and legal reforms. Similarly, Kigongo et al. (2024) identified factors such as stigma, religious beliefs, and fear of mistreatment as barriers to family planning access among youth in Uganda; the study did not directly address institutional follow-up or policy enforcement [6]

Social norms, peer pressure, and lack of comprehensive SRH knowledge are consistently highlighted as key behavioural drivers.

Social norms, peer pressure, and lack of comprehensive SRH knowledge are consistently highlighted as key behavioural drivers. Lahiri et al. (2023) revealed that social norms significantly influence contraceptive use, particularly among unmarried adolescents in Kilifi, Kenya [7]. Lahiri et al. (2023) showed that prevailing social norms often stigmatise contraceptive use and perpetuate myths about SRH, further discouraging access [7], similarly, Sahra et al. (2023) highlighted that stigma, cost, and lack of access remain barriers to service uptake.

Health system barriers are also prominent. Adolescents often encounter stigma, breaches of confidentiality, and judgmental attitudes from healthcare providers, which significantly hinder their willingness and ability to access sexual and reproductive health services. Integrating youth-friendly services into primary healthcare facilities has been shown to improve contraceptive uptake and overall service utilisation. Manet et al. (2023) showed that peer support and provider respect are essential to improving adolescent contraceptive uptake in urban contexts [8]. Additionally, community-based distribution of family planning methods plays a crucial role in expanding access, especially in rural or underserved regions where facility-based access is limited [9, 10].

Education and economic vulnerability amplify risks. Girls from low-income households with little or no education are significantly more likely to become pregnant during adolescence. Studies from, Ethiopia [11, 12], and Gambia [13] demonstrate how school dropout increases exposure to child marriage and early sexual activity. Conversely, school retention has been shown to delay sexual debut and improve SRH outcomes. Ikamari and colleagues [14] found that in urban Kenya, marital status and level of education are key determinants of unintended pregnancy.

Several interventions were found to be effective across the reviewed evidence base. Peer-led referral programmes [15], school-based sexuality education [16], and postpartum decision aids [17] have improved SRH knowledge and service uptake among adolescents. Moreover, studies emphasised the role of family and community engagement. Open parent-child communication and supportive community environments were found to contribute to better SRH decision-making among adolescents [18].
Evidence has also shown that adolescent pregnancy can be significantly reduced through multi-component, youth-centered interventions. The Adolescent Girls Initiative–Kenya (AGI-K) showed that combining school support, health education, financial empowerment, and violence prevention effectively delayed childbearing [19]. In Nairobi's informal settlements, classroom-based behavioral interventions resulted in a 46% decline in pregnancy-related school dropouts(20). Additionally, a rapid review of Kenyan studies identifies consistent strategies such as keeping girls in school, delivering sexual reproductive health education, and holistic empowerment programming as effective in preventing adolescent pregnancy[21].

Beyond Kenya, the Yathu Yathu study in Zambia provides a compelling example of how youth engagement in programme design can improve the effectiveness of adolescent health interventions[22]. By involving adolescents in the co-creation of SRH services, the programme enhanced relevance, acceptability, and uptake of youth-friendly services, demonstrating the critical role of participatory approaches in achieving better outcomes[22].

Table of included studies

Study (Author, Year)	Country	Key Findings	Recommendations
Lahiri et al., 2023	Kenya (Kilifi)	Social norms strongly influence contraceptive use among unmarried adolescents.	Target social norms through SBCC campaigns
Harada et al., 2024	Kenya (Kericho)	Poverty, lack of SRH knowledge, and stigma contribute to teen pregnancy	Promote CSE, school re-entry, and economic empowerment
Ikamari et al., 2013	Kenya (Nairobi)	Unintended pregnancy associated with education, marital status, and urban residence	Improve FP access and education for urban youth
Kigongo et al., 2024	Uganda	Youth face provider stigma and poor service quality	Train providers and create youth-friendly SRH environments
Flanagan et al., 2021	Uganda	Peer referral boosted FP uptake	Implement peer-led referral programs and youth-friendly clinics
Barrow et al., 2022	Gambia	High unplanned pregnancy linked to poverty, early sexual debut	Provide education and delay early marriage
Baku et al., 2017	Ghana	Positive parenting linked to better SRH outcomes	Promote parental involvement and SRH dialogue programmes
Mushy et al., 2023	Tanzania	Decision aids increased adolescent knowledge and FP uptake	Introduce decision support tools in postpartum care
Masiano et al., 2019	Malawi	Community-based FP programs expanded access	Expand Community-Based Distribution (CBD) programs to rural and underserved adolescents
Klinger et al., 2016	Madagascar	CSE improved knowledge and delayed sexual debut	Institutionalise reproductive health curriculum in schools
Manet et al., 2023	Guinea	Peer and provider attitudes influenced FP uptake	Train providers and involve peers in SRH delivery
Jejaw et al., 2025	Ethiopia	Community attitudes shape SRH behaviors	Implement community-sensitive SRH interventions
Titiyos et al., 2023	Ethiopia	Integrated family planning program expanded contraceptive options, strengthened health facilities, trained providers, and used community outreach to increase uptake of modern contraception and reduce unintended pregnancies, including among adolescents.	Scale successful youth-focused integrated family planning programs

Sarnquist et al 2017	Kenya	Classroom-based empowerment interventions reduced pregnancy-related school dropout	Expand school-based empowerment and life-skills programs
Austrian et al, 2016	Kenya	Multi-sectoral package (cash transfers, health education, financial empowerment, violence prevention) delayed childbearing and improved girls' wellbeing.	Scale up multi-component, youth-centered interventions that combine education, economic empowerment, SRH information, and violence prevention.
Simuyaba 2021	Zambia	Youth participatory co-design of SRH services led to increased acceptability and uptake of youth-friendly services.	Involve adolescents in program design and monitoring.
IDinsight Rapid Review (2020)	Kenya (national synthesis)	Effective strategies identified: keeping girls in school, SRH education, vocational training, holistic programs, and engaging boys.	Invest in holistic, evidence-based programs and integrate male engagement and school-retention strategies into adolescent pregnancy prevention initiatives.

Recommendations

- Enforce legal and policy frameworks: Ministry of Justice, Ministry of Gender, county governments, and law enforcement agencies should enforce and monitor laws protecting adolescents from GBV, child marriage, and FGM.
- Scale up social and behaviour change communication (SBCC) Strategies: Ministry of Health, Ministry of Education, NGOs, community-based organisations, and media houses should scale up social and behaviour change campaigns to delay sexual debut, shift harmful gender norms, and strengthen parental engagement on SRH. (Merged SBCC + parental engagement since both focus on changing norms and communication.)
- Strengthen youth-friendly services: Ministry of Health, County Health Departments, school boards, and faith-based health facilities should strengthen and expand adolescent-responsive SRH services in schools, health facilities, and communities.
- Enhance SRH education: Ministry of Education, Kenya Institute of Curriculum Development, Teachers Service Commission, and NGOs should enhance sexual reproductive health education in primary and secondary schools.
- Address economic and social barriers: Ministry of Education, Ministry of Public Service, Gender and Affirmative Action, Donors, and NGOs should address economic and social barriers by providing school meals, scholarships, sanitary towels, and financial support to keep vulnerable girls in school.
- Engage adolescents in programme design: Ministry of Health, Ministry of Education, youth-led organisations, NGOs, and county governments should engage adolescents meaningfully in the design, delivery, and monitoring of adolescent health programmes.

Conclusion

Reducing adolescent pregnancy in Kenya demands a multi-sectoral approach grounded in evidence. Successful interventions must address both the individual and structural factors contributing to adolescent pregnancy. Laws must be enforced, cultural norms shifted, and SRH education and services scaled up. Kenya can build on existing evidence and interventions to safeguard the future of its adolescent girls. Failure to act decisively risks reversing gains made in education, health, and gender equality, with long-term consequences for national development. While adolescent pregnancy is not inevitable, it is preventable. With strong political will, adequate financing, and coordinated efforts across government, civil society, and communities, Kenya has an opportunity to reduce adolescent pregnancy rates and secure a healthier, more empowered generation.

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