African Population and Health Research Center

Evaluation of the In Their Hands (ITH) Programme

Field Report of the midline qualitative study

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1.0 Introduction

1.1 Background

Evidence shows that adolescents in developing countries face structural, cultural, and legal barriers to obtaining sexual and reproductive health information and services. Such barriers include inability to afford services, negative attitudes among providers, breaches of confidentiality and privacy, lack of knowledge about available services and where to find them, stigma and taboos around sexuality, and laws that exclude adolescents from obtaining the information and services they need (Biddlecom et al, 2007; Chandra-Mouli et al, 2014). Reviews of evidence on what works in adolescent's sexual and reproductive health indicates there are some key and complimentary approaches used to increase uptake of sexual and reproductive health services among adolescents (Chandra-Mouli et al, 2015). These include training providers to offer youth friendly services, creating welcoming health facilities, and developing the support of community members for providing services to adolescents (Chandra-Mouli et al, 2015; WHO, 2018).

The In Their Hands (ITH) Program, funded by Children Investment Fund Foundation (CIFF) and implemented by three partners (Marie Stopes Kenya, Triggerise and Well Told Story) in Kenya since 2017, provides adolescent girls aged 15 to 19 years with free sexual and reproductive health (SRH) services through trained providers at private facilities. Mobilizers affiliated with the implementing partners mobilize adolescents and enroll adolescent girls either through short message service (SMS) or using Tiko cards. Adolescent girls who enroll in the T-Safe platform and use services are also rewarded with 'Tiko Miles' (these are reward points equivalent to a cash amount that can be redeemed for goods and services as an incentive for taking up the platform's services). By the end of the second year, there were 238 clinics and 42 pharmacies enrolled to provide subsidized SRH services to adolescent girls aged 15-19 on the T-safe platform in 20 priority counties. In each of the clinics and pharmacies, T-Safe providers serve adolescents who come for services through the platform. Since its inception in April 2017, more than 328,000 adolescent girls in Kenya have signed up to T-Safe, and by end of July 2018, approximately 208,615 adolescents had accessed SRH services at these private clinics (ITH dashboard, accessed on 22/08/2019).

As part of the external evaluation of the In Their Hands (ITH) project, the African Population and Health Research Center (APHRC) conducted midline evaluation which included qualitative in-depth interviews with adolescent T-Safe users, adolescents enrolled in the platform but did not use the services, providers and mobilizers to assess the adolescent user experience and quality of services as well as provider accountability under the T-Safe program.

1.2 Objectives of the Midline Study

The aim of the qualitative study was to assess adolescents' T-Safe users experience across quality dimensions as well as provider's experiences and accountability. The dimensions assessed include adolescents journey with the platforms**,** experience with the platform, perceptions of quality of services and how the ITH platforms changed provider behavior and accountability.

2.0 Evaluation Design and Methodology

2.1 Evaluation Design

In- depth interviews (IDIs) were conducted with different groups of respondents in Nairobi, Nakuru, Homa Bay and Kakamega counties. They were conducted with adolescents ITH service users, service providers and mobilisers. In-depth interviews (IDIs) with purposively selected adolescent ITH service users was to supplement the mystery client survey data to better understand adolescent experiences across key quality dimensions and outcomes.
It was also to explore how the platform was strengthening adolescent voice, autonomy and power. It was expected that an analysis of the IDIs was to provide a deeper understanding of user experiences, including views on service quality and challenges observed in seeking care that could be used by ITH implementing partners to inform enhancements to the model.

In order to understand the extent to which the ITH mobile platforms changed provider behavior and accountability, interviews were done with providers registered on the ITH platform. The IDI's with providers enabled us seek clarifications on service related issues emerging from the providers handing the adolescents seeking the ITH services. Moreover, IDI's were conducted with ITH mobilizers whose role in the project was to mobilize adolescents to register on the ITH platform and access Sexual Reproductive Health(SRH) services. IDI's with mobilizers was to provide an understanding of the mobilization process, how the Tiko Miles were perceived and accepted by the communities, and comparisons, contrasts and challenges in their experiences mobilizing adolescents for the ITH program.

2.2 Study Sites

For purposes of the midline survey, we purposively sampled four counties (Nairobi, Nakuru, Homa Bay and Kakamega) out of the 18 programme counties which were prioritized for the intervention.

2.3 Qualitative sampling

IDI participants were selected purposively from ITH intervention areas and facilities located in the four ITH intervention counties; Homa Bay, Nakuru, Kakamega and Nairobi respectively which were selected for the midline survey. Study participants were identified from selected intervention facilities. We interviewed one service provider of adolescent friendly ITH services per facility. Additionally, we conducted IDI's with adolescent girls' who were enrolled and using/had used the ITH platform to access reproductive health services or enrolled but may not have accessed the services for other reasons.

Sample coverage

We successfully conducted a total of 122 In-depth Interviews with 54 adolescents enrolled on the T-Safe platform, including those who received services and those who were enrolled but did not receive services, 39 IDIS with service providers and 29 IDIs with mobilizers. The distribution per county included 51 IDI's in Nairobi City County (24 with adolescent girls, 17 with service providers and 10 with mobilisers), 15 IDI's in Nakuru County (2 with adolescent girls,8 with service providers and 5 with mobilisers), 34 IDI's in Homa Bay County (18 with adolescent girls,8 with service providers and 8 with mobilisers) and 22 IDI's in Kakamega County (10 with adolescent girls,6 with service providers and another 6 with mobilisers.

Table 1.0 below presents the details of the response rate by county; and by interview type.

Table 1.0. Sample coverage by county; and by interview type

County	Interview Type			Total
	Adolescent Girls	Service Provider	Mobilizer	
Nairobi	24	17	10	**51**
Nakuru	2	8	5	**15**
Homa Bay	18	8	8	**34**
Kakamega	10	6	6	**22**
Total	**54**	**39**	**29**	**122**

2.4 Procedures for Data Collection

2.4.1 Selection, composition and training of the data collection team

Field interviewers for the study were selected based on their level of education, prior experience working on facility surveys, knowledge of the study areas, fluency in English and Kiswahili, and ability to communicate in at least one dominant local language spoken in any of the four counties sampled for the study. A team of 6 qualitative interviewers were recruited and centrally trained at the APHRC Campus, Nairobi. The data collection team was taken through a 5-day training session on the tools, data collection techniques and ethical considerations. The training consisted

of: (1) facilitated sessions on overview of the ITH program, the overall aims of the evaluation study, the study tools, research ethics; and (2) practical role play sessions. The training was facilitated by a team of researchers with vast field work experience drawn from APHRC. The trainees were objectively assessed on both theoretical and practical knowledge to ensure only those who were well prepared would proceed to the field.

Pilot test

A pilot test was done in two facilities within Korogocho slum in Nairobi County. During the pilot, the study management team was with the data collection team in the field to support the data collectors in case they encountered any issues with understanding of the survey tools and use of the audio recorders. Each field interviewer conducted at least 2 In-depth interviews. Data from the pilot was then assessed to help identify areas that needed to be addressed prior to the main data collection phase. The study tools were piloted to check for consistency; appropriateness of question formulation; difficult or sensitive questions and how to best ask them in the field. A debrief meeting was held after the pilot to share experiences and challenges that were identified by the data collection. Any concerns and challenges thereof were reviewed and necessary revisions made to the tools before the main survey.

2.4.2 Data collection tools

Separate IDI guides for adolescent girls, service providers and mobilisers respectively were used to collect data for the study. The guides were developed in English and then translated into Swahili, the predominant local language for data collection. These were back-translated into English by two translators working independently, and then repeatedly checked for accuracy by the study team. The tools were pre-tested by local data collectors by conducting pilot interviews after their training. The IDI tools were piloted in facilities within Korogocho slum in Nairobi county on a small sample of adolescent girls, service providers and mobilisers.

2.4.3 Data collection

Data was collected between May 6, 2019 and July 20, 2019. The field team was provided with a list of ITH health facilities sampled for the study in in the four Nairobi, Nakuru, Kakamega and Homa Bay counties. Face-to-face In-depth interviews were conducted with adolescent girls aged 15-19 years, ITH service providers and mobilisers for the T-Safe programme. The interviewers sought their permission and informed consent to participate in the study. The data collection teams worked closely with facility managers and CHVs attached to the programme but who themselves were not sampled for the survey to help identify and mobilize potential study participants. These were further screened by the interviewers for eligibility before they could be interviewed. Those who did not meet eligibility criteria were dropped.

2.4.4 Data quality control activities in the field

Data collection teams had daily debrief meetings under the supervision of field coordinators to review any challenges encountered during the day's interviews and to share areas requiring improvements based on feedback from review of submitted audio files and data transcription.

The debriefs were intended for improving quality of subsequent interviews. In addition, the team members used these meetings to share their daily experiences which were compiled and shared with the study management team and the rest of the survey team for action as was necessary.

2.4.5 Data transmission

Qualitative interviews were audio-recorded and the audio recordings were transmitted to APHRC study team by uploading the audios to google drive which was only accessible to the team. Related interview notes, participant's description forms and Informed consent forms were transported to APHRC offices in Nairobi at the end of data collection where the data transcription and coding was conducted.

2.4.6 Ethical considerations

The study protocol was reviewed by APHRC's internal scientific and ethics committee and adjudged to be scientifically sound. The protocol and data collection instruments were then approved to be ethically and scientifically sound by the AMREF Research Ethics and Scientific Review Committee (AMREF-ESRC). Research clearance for the study was granted by Kenya's National Commission for Science, Technology and Innovation (NACOSTI). Consent to collect data relating to ITH programme activities from programme affiliated facilities was also sought from health facility managers/administrators.

Field interviewers adequately informed potential participants about the purpose of the study and methods to be used; institutional affiliation of the research; any possible benefits and risks associated with their participation; right to decline to participate in the study, or to withdraw from it at any time despite granting consent without any reprisal whatsoever; and measures to ensure confidentiality of information they would provide before seeking their consent to participate. Adolescents younger than 18 years but who enrolled to receive services under the programme were considered as emancipated minors and were therefore individually consented just like their counterparts aged 18 to19 years.

Data collectors were trained on ethical issues to ensure that guidance on ethical conduct was clearly understood and implemented. The training included focused sessions and exercises regarding the meaning and process of informed consent, the importance of protecting the privacy of subjects, and confidentiality of the information obtained from them.

2.5 Data processing and analysis

Audio recordings from qualitative interviews were transcribed and saved in MS Word format. The transcripts were stored electronically in password protected computers and were only accessible to the evaluation team working on the project. A qualitative software analysis program (NVIVO) was used to assist in coding and analyzing the data. A "thematic analysis" approach was used to organize and analyze the data, and to assist in the development of a codebook and coding scheme. Data was analyzed by first reading the full IDI transcripts, becoming familiar with the data and noting the themes and concepts that emerged. A thematic framework was developed

from the identified themes and sub-themes and this was then used to create codes and code the raw data.

2.6 Challenges during fieldwork and possible mitigation

The data collection team encountered some challenges during the midline survey. However, the team was able to come up with mitigations that ensured that the integrity of the data collected as much as possible remained unquestionable. The challenges included the following:

i) Interruption with the data collection schedule, particularly because several clinics selected for the study had their agreements suspended or terminated, mobilizers off duty with the T-Safe platform deactivated from around April 2019. Thus it was difficult to find adolescents who recently visited or were visiting the clinics to seek SRH services. There were numerous cases where facilities indicated that they last offered ITH's ASRH services two or more months before the visit by the data collection teams at the start of the data collection in May 2019. This resulted in temporary suspension of the adolescents' survey since the original requirement was that the girls must have received services within two weeks preceding the visit by the data collection team. The data collection resumed only after the concern was addressed by Triggerize and the facilities were able to resume service provision.

ii) Tracing some health facilities. Some health facilities had changed names, even physical location on the ground but their original names are still retained as such in the programme's list of facilities. The data collection team was able to verify such inconsistencies and ensured that all facilities that were sampled for the midline survey were properly identified and the facility managers/administrators duly consented for the survey in their respective facilities

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