

Title of the Project

External Evaluation of the *In Their Hands Programme* - Kenya.

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Abstract

Background:

Adolescent girls in Kenya are disproportionately affected by early and unintended pregnancies, unsafe abortion and HIV infection. The In Their Hands (ITH) programme in Kenya aims to increase adolescents' use of high-quality sexual and reproductive health (SRH) services through targeted interventions. ITH Programme aims to promote use of contraception and testing for sexually transmitted infections (STIs) including HIV or pregnancy, for sexually active adolescent girls, 2) provide information, products and services on the adolescent girl's terms; and 3) promote communities support for girls and boys to access SRH services.

Objectives:

The objectives of the evaluation are to assess: a) to what extent and how the new Adolescent Reproductive Health (ARH) partnership model and integrated system of delivery is working to meet its intended objectives and the needs of adolescents; b) adolescent user experiences across key quality dimensions and outcomes; c) how ITH programme has influenced adolescent voice, decision-making autonomy, power dynamics and provider accountability; d) how community support for adolescent reproductive and sexual health initiatives has changed as a result of this programme.

Methodology

ITH programme is being implemented in two phases, a formative planning and experimentation in the first year from April 2017 to March 2018, and a national roll out and implementation from April 2018 to March 2020. This second phase is informed by an Annual Programme Review and thorough benchmarking and assessment which informed critical changes to performance and capacity so that ITH is fit for scale. It is expected that ITH will cover approximately 250,000 adolescent girls aged 15-19 in Kenya by April 2020. The programme is implemented by a consortium of Marie Stopes Kenya (MSK), Well Told Story, and Triggerise. ITH's key implementation strategies seek to increase adolescent motivation for service use, create a user-defined ecosystem and platform to provide girls with a network of accessible subsidized and discreet SRH services; and launch and sustain a national discourse campaign around adolescent sexuality and rights. The 3-year study will employ a mixed-methods approach with multiple data sources including secondary data, and qualitative and quantitative primary data with various stakeholders to explore their perceptions and attitudes towards adolescents SRH services. Quantitative data analysis will be done using STATA to provide descriptive statistics and statistical associations / correlations on key variables. All qualitative data will be analyzed using NVIVO software.

Study Duration:

36 months – between 2018 and 2020.

1. Introduction

1.1 Background

Evidence exists to show that adolescents in developing countries are more vulnerable to early and unintended pregnancies and unsafe abortion than their counterparts living in other parts of the world. This has partly been attributed to poor access to sexual and reproductive health (SRH) information and services, early sexual debut, early marriage and poverty among others [1, 2]. Each year an estimated 21 million pregnancies occur among adolescent girls of age 15-19 years in developing countries, almost half of which (49%) are unintended [3, 4]. This results in estimated 16 million births, about 3.9 million unsafe abortions and over a million miscarriages annually [3, 4].

Adolescent girls in Kenya are also disproportionately affected by early and unintended pregnancies, unsafe abortion and HIV infection. According to the 2014 Kenya Demographic and Health Survey (KDHS), 37% of girls and 44% of boys aged 15 to 19 years have had sex [5]. Some 18% of Kenyan adolescents become mothers as teenagers, effectively ending their schooling and endangering their future economic opportunities. As a result of the prevailing high level of unintended pregnancy, adolescent girls in Kenya account for nearly half of severe abortion related complications, and make up 17% of post abortion cases treated at health facilities [6]. Moreover, dropping out of school puts girls at greater risk of early and unintended pregnancy and HIV infection [5, 7]. While the incidence of new HIV infection is higher among adolescent girls due to biological and social vulnerabilities, less than half of adolescent girls report comprehensive knowledge of HIV AIDS in Kenya [1].

These are a few of the many reasons why youth friendly sexual and reproductive health services are central to girls' empowerment. It is a proven way of reducing maternal and newborn deaths. However, although contraceptive use has greatly improved among married and sexually active young women in Kenya in the last few decades, yet a high unmet need for contraception remains. According to the 2014 KDHS, six out of ten married adolescents in Kenya are in need of a family planning method, out of which 23%

have an unmet need. Sexually active unmarried adolescents have the highest unmet need for contraception [5]. Improving adolescent knowledge of, access to, and utilization of sexual and reproductive health services requires addressing both demand- and supply-side barriers that hinder uptake. Demand-side barriers include individual, socio-cultural and economic factors; stigma associated with contraceptive use among unmarried women; and pressure for married adolescents to begin childbearing [1, 8]. Supply-side barriers include poor SRH service infrastructure, provider bias, availability and cost of contraceptive commodities and lack of youth friendly service [1, 8].

Review of existing research evidences show that sexual and reproductive health (SRH) education, counselling and contraception provision are effective in increasing sexual knowledge, contraceptive use and decreasing adolescent pregnancy [2, 9]. But such policies and programs are either non- existent or are poorly implemented in many developing countries. The Government of Kenya, along with several health and development partners, has been striving to improve adolescent sexual and reproductive health by increasing access to quality SRH products and services. In 2015, the National Adolescent Sexual and Reproductive Health Policy was revised to provide guidance to government ministries and development partners on how to respond to adolescents SRH needs. The policy aims to enhance the SRH status of adolescents in Kenya and contribute towards realization of their full potential in national development [10].

1.2 Description of ITH Programme

The ITH programme brings together the largest youth edutainment network (Well Told Story), the nation's largest provider of sexual health services (Marie Stopes Kenya), and Triggerise – an innovator in mobile based incentives. The programme objectives are threefold namely; 1) to get adolescents to want contraception and to know if they have sexually transmitted infections (STIs) including HIV or are pregnant, 2) to provide information, products and services on the adolescent girl's terms, and 3) to get communities in the selected pilot county to support girls and boys to access SRH services. The ITH ecosystem and platform will include the following components:

- a) A go-to ITH platform (web, media and hotline) where adolescents, service providers and connectors will be able to register. The platform will be promoted through Shujaaz multi-channel platforms, PSK, MSK, DKT, FHOK networks of providers and pharmacists.
- b) Adolescent girls will be able to access information on contraception and services as well as free SRH services via the T-Safe platform at nearby registered providers. They will also be able to rate providers on their services they received.

- c) Registered providers (clinics, pharmacies and new innovative channels) will offer services free for adolescents, opening a new market and incentivising them to provide youth friendly services.
- d) Network of teen-friendly last mile connectors (mobilisers) will provide information and referrals will be developed. These include Shujaaz Supafans, Marie Stopes Diva Connectors and Community Health Volunteers, Tiko Pro agents, as well as other mobilisers that may be contracted by Triggerise from time to time to generate demand, such as dance4life agents of change
- e) All parties will be incentivised on positive behaviours: providers when they are rated high, connectors for effective referrals, and girls themselves when they interact on our platform
- f) User-controlled methods such as medical abortion, Sayana Press and HIV self-testing will be offered via the platform subject to availability of funding to subsidize their access.

Lastly, the programme will demonstrate an intervention in one country to support efforts to change the public opinion on adolescent sexual and reproductive health.

To achieve this, ITH's key implementation strategies are to tailor information provision and expand use of multiple adolescent touch points to increase adolescent motivation for service use, as well as create a user-defined ITH ecosystem and platform to provide girls with a network of subsidized and discreet SRH services. By the end of April 2020, the programme is expected to reach approximately 250,000 adolescent girls aged 15-19 in Kenya who use sexual and reproductive health services via the ITH platform in selected sub-locations in these priority counties.

The African Population and Health Research Center (APHRC) has partnered with the ITH implementing partners to conduct an independent impact evaluation of the ITH programme. The evaluation will focus on assessing to what extent and how ITH is (1) increasing access to quality sexual and SRH products and services among adolescent girls, and (2) improving community support in Kenya.

2. Problem Statement

The ITH investment is designed to develop a movement, driven by youth to normalize adolescent sexual health, reduce pregnancy and end unsafe abortion among Kenyan adolescents. Over three years, between 2017 and 2021, ITH will reach 250,000 girls with contraception, HIV counselling, testing and care, and safe abortion or post-abortion

care, averting approximately 68,000 pregnancies and 21,000 abortions among girls aged 15 to 19 in 18 priority counties. Available evidence shows that interventions that increase youth uptake of SRH services and driven by the youth themselves may reduce pregnancies and unsafe abortions among adolescents, However, in Kenya there is no existing evidence to that effect. The ITH programme will be the first national network of youth friendly service providers as defined by adolescent girls and including such interventions in Kenya. This evaluation study therefore seeks to generate evidence on how the interventions in the programme interlink to help girls start valuing their sexual health and wanting services, and involves designing these choices *on* their terms, and making providers accountable, creating an environment where girls are fully supported to make this decision, document and share the findings and lessons learnt throughout the implementation period.

3. Literature Review

There are several reasons why youth friendly sexual and reproductive health information and services are central to adolescent health and wellbeing in developing countries. Adolescent girls are disproportionately affected by early and unintended pregnancies, unsafe abortion and HIV infection. In Kenya for instance, 37% of girls and 44% of boys aged 15 to 19 years are sexually active and some 18% of Kenyan adolescent girls become mothers as teenagers, effectively ending their schooling and endangering their future economic opportunities [5]. Although contraceptive use has improved over the years, about a quarter of adolescent girls in Kenya have unmet need for contraception and are at high risk of unintended pregnancies [5]. As a result of the prevailing high level of unintended pregnancy, adolescent girls in Kenya also account for nearly half of severe abortion related complications, and make up 17% of post abortion cases treated at health facilities [6].

The reasons for low contraceptive uptake among adolescents are complex, including lack of agency and control over their lives, lack of access to reliable sources of contraception information and financial resources. Broader socio-economic factors such as poverty, lack of education and limited economic opportunities among girls may also contribute to adolescent pregnancy [1]. Socio-cultural and gender norms that promote early marriage and childbearing and norms that stigmatize pre-marital sex also inhibit unmarried girls from seeking contraception services [11, 12]. Moreover, young people, particularly girls, encounter significant barriers to accessing quality health care, including provider bias, age restrictions or stigmatization when seeking services and concerns about

confidentiality [9]. They often find mainstream primary care services unacceptable because of perceived lack of respect, privacy and confidentiality, fear of stigma and discrimination and imposition of the moral values of health-care providers [1, 8]

Increasingly, researches on programs designed to reduce teenage pregnancy and the adverse consequences of early child bearing have identified which interventions have proved effective in reducing teenage pregnancy. Review of existing evidences show that sexual and reproductive health education, counselling and contraception provision are effective in increasing adolescent's knowledge of sexuality and health, contraceptive use and decreasing adolescent pregnancy [2, 9, 13]. In addition, the potential of several methods to increase youth uptake of services, including linking of school education programs with youth friendly services, life skills approaches and social marketing and franchising are among the key interventions implemented to reduce teenage pregnancy and associated challenges. There is also evidence that the involvement of key community gatekeepers such as parents and religious leaders is vital to generating wider community support and increase contraceptive use among adolescents.

The central tenet of adolescent friendly sexual and reproductive health services is providing services that respond to the individual needs of adolescents. But health policies and programs in developing countries have struggled to figure out how services should respond to the needs of adolescents. The recent WHO global standards for quality health-care services for adolescents identified eight standards of quality in the delivery of health services for adolescents: health literacy, community support, appropriate package of services, provider's competencies, facility characteristics such as convenient operating hours, a welcoming and clean environment, privacy and confidentiality, equity and non-discrimination, adolescent's participation and data and quality improvement [14]. Adolescent-friendly SRH services should meet the individual needs of adolescent males and females who return when they need to and recommend these services to friends. Moreover, their involvement in the planning and monitoring of services also promotes quality because it ensures that services are acceptable to adolescents and increases the likelihood that adolescents will refer the services to their peers. Lessons learnt from successful programs showed that they should involve adolescents in the planning process, gain community buy-in and use a combination of elements that fits with the needs of that particular community [15].

4. Evaluation Objectives

4.1 General Objective

To assess if and how the In Their Hands (ITH) partnership model and integrated system of delivery meets its intended objectives and the needs of adolescents, promotes adolescent voice, decision-making autonomy, power dynamics and community support for adolescent sexual and reproductive health.

4.2 Specific Objectives

The study seeks to assess:

1. The extent to which and how the new Adolescent Reproductive Health (ARH) partnership model and integrated system of delivery is working to meet its intended objectives and the needs of adolescents.
2. Adolescent user experience across key quality dimensions and outcomes.
3. How the ITH programme has influenced adolescent voice, decision-making autonomy, power dynamics and provider accountability.
4. Assess how community support for adolescent reproductive and sexual health initiatives has changed as a result of this programme.
5. The replicability, scalability and sustainability of the ITH programme in Kenya and globally.

5. ITH's Theory of Change

The ITH program assumes that teenage pregnancy will be prevented by increasing access to quality SRH products and services among adolescent girls 15-19 and by improving community support for adolescent SRH. The theory of change shown below stipulates that by creating demand for and awareness of the mechanisms to prevent teenage pregnancy, by providing adolescent friendly and discrete sexual and reproductive health services and mobilizing community support for adolescent SRH, sexually active adolescents will utilize SRH services which will ultimately reduce teenage pregnancy. The philosophy goes - 'I want it' 'on my own terms' and 'I am being supported'.

To this end, the three partners will implement interventions that will respond to adolescent girls' needs, aspirations and motives to prevent unintended pregnancy and prevent themselves from STI/HIV infection. Marie Stopes Kenya will provide a network of youth friendly SRH services through their clinics and social franchise AMUA network. This network will be compensated by additional networks from PSK, FHOK and other-to-be-determined providers to be enrolled by Triggerise. This will be done using a user-defined ecosystem and platform that links girls with a network of service providers and subsidized and discreet SRH services. The ITH ecosystem or platform is a national network of youth-

friendly service providers as defined by adolescent girls and includes a go-to ITH platform (web, media and hotline) where adolescents, service providers and connectors will be able to register. Adolescent girls will access information on contraception and services as well as free SRH service at nearby registered providers via the T-safe platform. They will also be able to rate providers on the services they received. Registered providers (clinics, pharmacies and new innovative channels) will offer services free for adolescents, opening a new market and incentivising them to provide youth friendly services. A network of teen-friendly connectors including Shujaaz Supafans, Marie Stopes Diva Connectors and Community Health Volunteers, Tiko Pro agents as well as other providers to be contracted by Triggerise from time to time to generate demand such as the dance4life agents of change- will provide information and referrals. All parties will be incentivised on positive behaviors': providers when they are rated high, connectors for effective referrals, and girls themselves when they interact the ITH platform.

Well Told Story will create demand for and awareness of the services through their national multi-media platform 'Shujaaz'. It will expand and tailor the work of Shujaaz media and other social media options to increase adolescent motivation for service use. WTS will also implement an intervention in one selected county that will support efforts to change the public opinion on adolescent sexual and reproductive health using mass media and other possible avenues. Triggerise will provide the mobile platform to ensure easy access to the free services at specified health facilities. It has created a user-defined ITH ecosystem and platform to link girls with a network of subsidized and discreet SRH services provided MSK, PSK, FHOK, private Pharmacies, drug shops and AMUA network of private clinics. Figure 1 below presents ITH's theory of change (ToC).

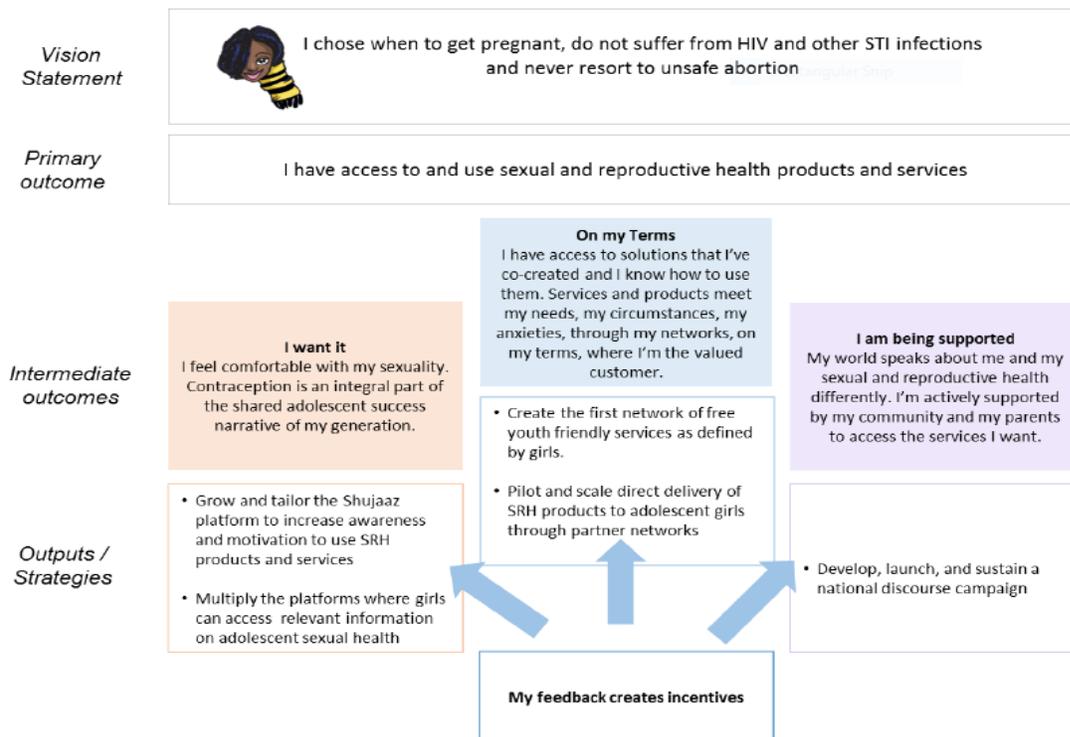


Figure 1: ITH program theory of Change

6. Research Questions

The evaluation will seek to answer the following overarching questions:

1. To what extent, and how is the new ARH partnership model and integrated system of delivery working to meet its intended objectives and the needs of adolescents?
2. What are the adolescent user experiences of the ITH programme across key quality dimensions and outcomes?
3. How has the ITH programme influenced adolescent voice, decision-making autonomy, power dynamics and SRH service provider's accountability?
4. How has community support for adolescent reproductive and sexual health initiatives changed as a result of this programme?
5. To what extent is the ITH programme replicable, scalable and sustainable in Kenya and globally?

7. Study Design and Sampling Strategy

7.1 Evaluation Design

The ITH programme is being implemented in two phases between April 2017 and end of March 2020: a formative planning and experimentation in the first year from April 2017 to March 2018, and a national roll out and implementation from April 2018 to March 2020. Lessons learned from the first phase of implementation were fed into the larger roll out of the programme during phase two. Thus, following the strategies and activities of the project, a participatory developmental evaluation that involves innovative and participatory evaluation approaches will be used to understand programme achievements and acceptability of the programme by adolescents, providers and communities. The evaluation uses mixed methods design including a before and after evaluation design to systematically assess the delivery, effectiveness and effects of the programme. It will incorporate routinely collected programme monitoring data and additional data collection to fill the gaps and to complement the ITH monitoring data. The proposed evaluation methods (detailed below) will ensure that key learning questions are answered and that adolescent voices and perspectives are integrated into the planning, implementation, monitoring and evaluation of the programme.

7.2 Routine monitoring data

The evaluation will depend on routine monitoring data collected by the implementing partners from participating facilities (MSK clinics, AMUA, Pharmacies) to evaluate the achievements of the primary outcome of the project- the number of adolescent girls accessing SRH services via ITH platform, number of girls receiving free HIV testing and number of girls accessing contraception via MSK services. The three partners routinely collect quantitative monitoring data on the programme via their health services, media and mobile platforms. The ITH database managed by Triggerise will document the number and types of SRH services provided, number of providers registered on the platform and several other indicators related to the primary outcome of the evaluation. Additional data gathered through the routine monitoring system include: gender, year of birth, date of enrollment, agent or mobilizer who enrolled the girl onto t-safe platform (Tiko pro, msk mobilizer/ diva connector, shujaaz superfan) and service provider's information (location and organization). To assess if the ITH intervention is meeting its targets and more adolescents are accessing contraception services at sites with ITH interventions, ITH monitoring data on service delivery will be analyzed.

Few additions of adolescents demographic characteristics (rural - urban residence, county, marital status and education level) to the data gathered through the ITH platform have been suggested by the evaluators to enable disaggregation of the data. This will enable the evaluation team to assess how the ITH program has reached adolescents of diverse socio-economic and geographic categories. Analysis will involve comparing achievements with planned targets of services delivery at different time points, looking at whether adolescents of different geographic and socio-economic background have benefited from the program. We will also examine data on other intermediate outcome indicators, as key intervention activities and outputs lead to the achievement of these primary outcomes.

7.3 Adolescent Consultative Forum

In addition to the routine monitoring data a participatory approach in the Performance Evaluation (PE) will involve adolescents in the analysis and interpretation of data, and the generation of findings and recommendations for the ITH partnership. As important stakeholders in the program, adolescents can provide valuable input on designing youth friendly evaluation tools. Adolescents can provide important insights in to the evaluation approaches, including data collection, analysis and use of evidence for program improvement. As part of the evaluation, we will organize adolescent consultative forums – which includes a minimum of 8-10 adolescent ITH service users twice during the project period in Nairobi, Homa Bay and Narok counties. This will create opportunities for adolescents to express themselves, voice their ideas and interests, and provide input into project evaluation. The ACF will focus on generating timely, actionable information that can be used by the evaluators and the implementing team to direct resources and attention, to meet adolescents’ needs for sexual and reproductive health services during the course of actual implementation. This participatory aspect will incorporate questions and methods to ensure relevance of evidence for adolescents, as well as to promote their ownership of the findings.

7.4 Qualitative Data Collection

Qualitative studies will be used to address several evaluation questions of the study; to assess to what extent and how the new ARH partnership model and integrated system of delivery is working to meet its intended objectives and the needs of adolescents; to explore adolescent user experience, adolescents’ voice, decision-making autonomy, power dynamics and provider accountability as well as community support. For this

purpose in- depth interviews (IDIs) and focus group discussions (FGDs) will be conducted with different groups of respondents. In-depth interviews will be conducted with adolescents ITH service users and service providers. In-depth interviews (IDIs) with purposively selected ITH service users will supplement the mystery client survey data to better understand adolescent experiences across key quality dimensions and outcomes. It will also explore how the platform is strengthening adolescent voice, autonomy and power. It is expected that an analysis of the IDIs will provide a deeper understanding of user experiences, including views on service quality and challenges observed in seeking care that can be used by ITH implementing partners to inform enhancements to the model. The IDI's with ITH service users will be used to inform the mystery client survey and ideally comes before the mystery client survey. Moreover, to understand the extent to which the ITH media platforms changed provider behavior and accountability, interviews will be done with providers registered on the ITH platform. The IDI's with providers will take place after the mystery client survey with service users to enable us seek clarifications on service related issues emerging from the exit interview.

Focus group discussion will be conducted with ITH mobilizers whose role in the project is to mobilize adolescents to register on the ITH platform and access SRH services. The FGDs with mobilizers of the ITH program will provide an understanding of 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. The FGDs with the community (community leaders and parents) will explore community's attitudes towards adolescent sexuality and their support for adolescent's reproductive health services.

Moreover, focused ethnographic study (FES) will be conducted with a small number of adolescent girls who participated in the adolescent survey to identify adolescent girls' SRH concerns, how they address their SRH concerns, community support for SRH issues, barriers to accessing the ITH platform, as well as their perspectives on how the barriers can be addressed at the community level and at the ITH facility level. Focused ethnography (FE) is a group organized qualitative research technique that is used to identify specific cultural perspectives held by sub-groups of people within a context-specific and problem-focused framework [17]. Focused ethnography employs structured interviewing techniques that involve free-listing and rating of selected issues of concern. This method is ideal for adolescents as it eliminates the group dynamics and social pressures associated with adolescents in groups, which can influence results. By using individual written responses the FE method minimizes confidentiality concerns over less socially desirable or personal experiences.

In-depth interview and focus group discussion guides will be developed and translated into the local language for data collection. This will be back-translated into English by two translators working independently, and will be repeatedly checked for accuracy. The tool will be pre-tested by local data collectors by conducting pilot interviews during their training. A minimum of twenty IDIs will be conducted with each group of respondent's adolescent service users and providers. Adolescent service users and providers will be recruited from the MSK, PSK, FHOK and private facilities (AMUA) associated with the ITH programme. For purposes of this study we are defining service providers as physicians, midwives, clinical officers, pharmacists and/or nurses who are involved in the direct provision of SRH services for adolescents. All direct care providers at participating study sites will be eligible to be interviewed. Similarly, a minimum of eight FGDs with the community and three FGDS with ITH mobilizers will be conducted in the study areas all disaggregated by residence and county. The IDI respondents and FGD participants will be selected purposively from ITH intervention areas and facilities located in the two ITH intervention counties selected for the study including Homa Bay (Nyanza), and Narok (Rift valley). Sub-counties and wards of ITH intervention will be identified and participants selected accordingly.

7.5 Quantitative Data Collection

The quantitative study involves a community based before and after evaluation design with pre and post surveys with adolescents aged 15-19 years and health facility based mystery client survey to answer key evaluation questions of the program; how has the ITH changed adolescent access to information, health care services use and decision making autonomy and how is the platform strengthening adolescent voice, autonomy and power?

Mystery Client Survey

To examine the quality of sexual and reproductive health services provided at the facilities linked to the ITH program, we will conduct a mystery client survey at purposively selected clinics (a minimum of 30 clinics) in ITH intervention counties. The use of 'mystery client' evaluation methods in assessing quality of service provision has proven to be reliable, feasible and acceptable in different settings [18, 19]. It is a useful method in capturing 'real life' accounts of provider performance and environments in which sexual and reproductive health (SRH) services are provided. It is believed that since the providers do not know they are being observed, in most cases the information gathered through

mystery client encounters reflects providers' normal performance. This method involves a trained observer posing as a patient who records their experiences of provider encounters. After visiting the health facility, each mystery client will record their perception of the quality of services and the friendliness of the service environment. This includes the quality of services received, including cost, counseling, information provision, privacy, providers' attitudes, and waiting time. Each facility will be visited by at least two mystery clients on different days and acted out the same scenario to compare the individual assessments of the quality of services.

Adolescents Survey

To assess how ITH has influenced adolescent voice, autonomy and power dynamics, we will conduct a before and after evaluation study comparing indicators before and after the intervention. Data will be gathered through adolescent survey at baseline and endline in two intervention Counties at two time points – before and after the intervention. We will conduct a survey among a representative sample of adolescent girls living in both urban and rural ITH implementation areas to understand whether ITH has changed adolescents' access to information, use of SRH services and SRH-related decision making autonomy. The end line survey will include questions on adolescent's exposure to ITH program to evaluate how demand generation activities have influenced adolescent girls decision making on SRH issues, uptake of adolescent friendly sexual and reproductive health (ASRH) services and knowledge of sexual and reproductive health issues. The concepts of adolescent voice, autonomy and power dynamics are operationally defined (see below) and we will use standard tools used in similar surveys in Kenya and other developing countries to measure these concepts through the exit interview and adolescent survey.

7.6 Definition of key concepts

Adolescents: according to the WHO, adolescents refers to any person between the ages of 10 and 19 years. This study focuses on adolescents of age 15-19 years only.

Adolescent voice is measured by examining adolescent involvement in different aspects of the project. In the literature on adolescent SRH, adolescent voice is defined through the following elements: space, expression, audience and influence.

- Space: opportunity to express a view
- Expression: facilitated to express their views
- Audience: Views listened to
- Influence: Views are acted upon, as appropriate

Decision making autonomy is measured by gathering adolescent views on decisions about the future (future goals), decision about having children – if and when, decisions about sex and decisions about contraceptives.

Power dynamics is examined by interrogating the extent to which the adolescent – provider relationship is influenced by age related power differences i.e. adult – adolescent, position and the effect of such power dynamics on adolescent’s choice of contraceptives.

Quality of care is defined as the extent to which health services provided to adolescents improve desired health outcomes among adolescents. We focus on users experience, availability, accessibility, affordability, appropriateness and acceptability of services.

7.7 Sampling and sample determination

For the mystery client survey, a purposive sample of health facilities linked to the ITH program will be used. Four categories of clinics linked to this project: Marie Stopes Kenya (MSK), Tunza or PSK franchised clinics, Family Health Options Kenya (FHOK) and private facilities associated with the MSK (AMUA) and Pharmacies and shops will be included. A minimum of five clinics will be included from each of these facility types. In each of the sampled participating facilities, trained researchers of age 15-19 years will visit the selected facilities as mystery clients to request contraception and HIV / STI information and counselling.

The sampling of adolescents for the household survey is based on expected changes in adolescent’s intention to use contraception in future. According to the Kenya Demographic and Health Survey 2014, 23.8% of adolescents and young women reported not intending to use contraception in future. This will be used as a baseline proportion for the intervention as it aims to increase demand and reduce the proportion of sexually active adolescents who do not intend to use contraception in the future. Assuming that the project will achieve an impact of at least 2.4 percentage points in the intervention counties (i.e. a reduction by 10%), a design effect of 1.5 and a non-response rate of 10%, a sample size of **1885** is estimated using Cochran's sample size formula for categorical data will be adequate to detect this difference between baseline and end line time points.

Based on data from the 2009 Kenya census, there are approximately 0.46 adolescents girls per a household, which means that the study will include approximately **4876** households from the two counties at both baseline and end line surveys.

County Selection

The ITH project will be implemented in 18 eighteen counties in Kenya with most counties concentrated in Nyanza, rift valley and western regions. It is implemented in all the six counties in Nyanza (Kisumu, Migori, Kisii, Siaya, Myamira, and Homa Bay). In Rift Valley the project is implemented in Kericho, Trans Nzoia, Kajiado, Narok and Nakuru). For the purpose of the evaluation, we purposively select two counties from the counties where ITH intervention has not yet begun – one from Nyanza (Homa Bay) and another from Rift valley (Narok). The selection of the counties will also consider other important criteria of availability of other similar interventions on adolescent sexual and reproductive health, and geographic and socio-economic similarity with the counties where the project is implemented. To date, the ITH intervention has not yet started in the majority of eighteen counties. The selection of the counties will be purposive and consultative with ITH project partners to identify two ideal counties which represent majority of the other eighteen counties. However, for objectivity of the evaluation, the evaluation counties will be blinded to the implementing partners.

Inclusion and Exclusion Criteria:

The ITH project focuses on adolescent girls of 15-19 years of age. The interventions include setting up youth friendly services at MSK facilities, franchised private clinics (AMUA), Family Health Options Kenya (FHOK) and Tunza (population Services Kenya) clinics, pharmacies and Tiko Pro shops. Pharmacies and Tiko Pro shops provide little counselling on SRH services for adolescents, but are useful to include in the mystery client surveys. All these facilities linked to the ITH project will be included in the health facility based qualitative and quantitative studies.

The adolescent survey will include participants from both rural and urban areas in the two selected implementation counties. The Inclusion criteria are:

- Adolescent girls whose age is between 15-19 years
- Have been living in the study areas for at least 6 months preceding the study.
- Must be a member of the sampled households in the study counties located either in the intervention counties.

On the other hand, exclusion criteria of age, being non-resident of the study areas, and not residing in the sampled households for at least 6 months preceding the study apply.

8. Data Collection

8.1 Recruiting participants for the study

Within the selected counties, we will randomly select sub-counties and wards from places where the ITH program are to be implemented. In each of the ITH intervention counties, there are sub-counties that have been prioritized for the project and our data collection focuses on these sub-counties selected for intervention. A stratified sampling procedure will be used to select wards/villages from sub-counties. Then households will be selected from each wards/village or primary sampling unit after all households in the villages are listed.

The study team will work with the county management, local and community leaders to obtain permission to work with the necessary government and community leaders to map out the boundaries of sub-counties and wards. Once the boundaries are established, field workers will visit each household within the boundaries of the selected ward/village and will provide a statement about the study to the head of household and ask if there is a girl living in the house between the ages of 15-19 years who may be available to participate in the survey. If there is an eligible participant, the interviewer will move onto the recruitment and will obtain informed consent from the parent/guardian, and obtain assent from the adolescent girl if she is aged under 18, OR will obtain informed consent from girls 18-19 years and emancipated minors (married 15-17 year olds living within their partners'/husbands' household). Once consented/assented the survey will be administered. The survey is designed so that the first several sections of the survey are asked to all eligible girls. Girls who report that they have ever had sex will complete additional sections of the survey (details about the survey are provided in under Study Design and Methods. If the eligible participant is not available on the first visit, the fieldworker will make two additional attempts to contact that participant. Eligible participants not reached after a third attempt will be considered as not available.

The evaluation data collection is implemented in three phases. In phase one we collect baseline data in the form of adolescent survey and FGD with community members to measure baseline levels of key indicators and identify main barriers to adolescent's sexual and reproductive health. During the second phase we collect health facility related data

from clinics, adolescent service users and providers to assess the quality and friendliness of the services as well as adolescent users experience and provider accountability. The third and final round of data collection involves endline survey with adolescents and FGDs with community members to examine the measurable outcomes the ITH intervention.

8.2 Qualitative Sampling

Focus Group Discussion participants will be recruited from the villages where the ITH adolescent household survey is conducted in both counties. A convenience sample of consenting adults living in the villages will be invited to participate in the FGDS. The discussion will be conducted in local languages. A facilitator and note-taker will be trained how to use the focus group guide, how to facilitate the group to elicit the information sought, and how to take detailed notes. All focus group discussions will take place in the local language and be tape-recorded, and the consent process will include permission to tape-record the session. Participants will be identified only by their first names only and participants will be asked not to share what is discussed outside of the focus group. Participants will be read an informed consent form and asked to give written consent.

For the FES with adolescents, a convenience sample of consenting adolescents who were interviewed during the household survey will be invited to participate in the FES and discuss on the barriers of adolescent SRH. At baseline we conduct two FES per county – two in Homa Bay and two in Narok.

For the provider IDIs, Participants will be selected from the chosen intervention facilities using Triggerise provider database; the providers trained to provide adolescent friendly sexual and reproductive health services. We will interview one provider of Adolescent friendly ITH services per facility. A facilitator and note-taker will be trained how to use the IDI guide, how to facilitate the interview to elicit the information sought, and how to take detailed notes.

In depth interviews will be conducted with adolescent girls that are already enrolled and using the ITH platform to access reproductive health services. As such, sampling of adolescent girls will be done in collaboration with ITH implementers, who will thereafter contact sampled respondents directly through established communication channels including direct contact of the girls through mobilizers, project meetings/forums with ITH users or direct phone calls. Adolescent girls that agree to participate in the study will be invited for face to face interviews in venues that will guarantee their privacy

8.3 Instruments

Two quantitative tools adolescent survey questionnaire and mystery client tool will be used to collect data about the adolescents' perception about the ITH programme and its impact on their access to information, health care services and decision making autonomy.

The adolescent survey questionnaire will cover; socio-demographic and household information, SRH knowledge and sources of information, sexual activity and relationships, family planning knowledge, access, choice and use when needed, exposure to family planning messages and voice and decision making autonomy (see Annex 1).

The mystery client interview guide lists questions that need to be explored during the interviews with the mystery clients. This focuses on the service delivery environment, quality of counselling and service provision, interactions with provider, decision making, information provision, and counselling and method choice among others (see Annex 2). Mystery clients will be given a copy of the interview guide to make notes on or make separate note immediately following the visit, and then will be interviewed shortly after.

The questionnaire will be piloted before the data collection and the questions reviewed for appropriateness, comprehension and flow. The adolescent survey will be piloted among a sample of 30 adolescent girls 15-19 from a community outside the study counties. The Mystery client guide as well as all the qualitative tools will be piloted on a few sample of facilities and individuals before the actual data collection begins.

8.4 Recruitment and Training of data collectors

Interviewers will be selected based on level of education, prior experience working on similar surveys and knowledge of local languages. The recruitment will follow a transparent process consistent with high ethical standards. For each of survey round, we will recruit a minimum of twelve interviewers (two qualitative and ten quantitative) per county. All fieldworks will undergo a 5-day training workshop on the tools and data collection techniques and ethical considerations from a central venue, preferably in Nairobi. The workshop will comprise: 1) facilitated sessions on overview of the ITH programme, the overall aims of the evaluation study, the study tools, research ethics; and 2) mock interviews. The training course will be facilitated by researchers with vast field work experience drawn from APHRC, including senior research staff, and research officers.

8.5 Team Composition

Interviewers will be deployed in two teams composed of qualitative and quantitative data collectors. Data collection exercises will be overseen by a full time field coordinator supported by 4 field team leaders, 2 each for quantitative and qualitative data collection teams respectively who will directly supervise a team of 4-6 data collectors each. The team leaders and data collectors will be trained on research ethics, interview procedures, data quality and use of the automated data collection process.

A field coordinator will be in charge of coordinating and verifying the quality of the work done by the fieldworkers. During the data collection period, the field coordinator will consult regularly with the project management team in APHRC on achievements and constraints of the operation. These consultations will help make necessary adjustments to the data collection process. The quantitative data will be collected electronically and uploaded to a secure server at APHRC. Qualitative interviews will be audio-recorded and audio recordings will be transmitted to the APHRC's offices in Nairobi while related interview notes will be transported to APHRC offices at the end of data collection where the data transcription and coding will be conducted. The transcripts will be stored electronically in password protected computers and will only be accessible to the evaluation team working on the project. All interviews will be conducted in places and spaces free of potentially eavesdropping non-participants.

8.6 Field Quality Checks

During the data collection period, supervisors will consult regularly with the central coordination team on achievements and constraints of the operation. These consultations will facilitate any necessary adjustments to the data collection process. In the first week of data collection, a software developer will be available to perform onsite support where necessary. Thereafter, remote connection through TeamViewer will be used to offer support to troubleshoot any problems that may arise involving data capture (and data transmission) using the tablets.

Team leaders will work with their teams at the end of each day to review data captured on the tablets, looking for any errors, such as incorrectly filled forms, missing data and inconsistencies. Through sit-in interviews, supervisors will randomly observe each interviewer at least once per week during the survey implementation. This will help to verify that data collectors are following all the procedures outlined in the training and ensure that interviews are being conducted to the highest standards. In addition, all data collectors will review each questionnaire before leaving the households to be sure that

every applicable question has been asked and that responses recorded are clear and reasonable. They will also check that the skip instructions are correctly observed (i.e., for skip rules that are not automatically programmed into the tablets). A Quality Control Checklist will be used to that effect. Once all necessary checks are done by the team leaders, the data will then be synchronized into the APHRC data server.

8.7 Data Quality Assurance

Data quality assurance will focus on data accuracy, completeness, reliability, timeliness, confidentiality, precision and integrity. Data quality control will therefore be enforced at every point of data collection as much as possible to guarantee the results. Specifically, quality control will be enforced at the following points:

1. Sampling design: Appropriate sampling method will be used to ensure that the study is unbiased in the choice of respondents to be interviewed. This will ensure that only people who will actually give a correct indication for the greater population are interviewed.
2. Questionnaires design: Using the Open Data Kit (ODK)-based system, we will be able to enforce the following quality control requirements:
 - Applicable skip instructions: This will allow the respondents to answer only the questions that apply to them.
 - Response format: Specification of the exact type of format of response expected for instance, age field only accepts three (3) cell entries reflecting complete years and date of birth accepts eight (8) cell entries starting with 2 cells for date, then 2 for months and 4 cells for year. This will ensure that errors from the field are minimised and only responses that are correct and within range are captured.
 - Compulsory Questions: The ODK-system allows for enforcement of compulsory questions, where necessary before moving on to the next question.
 - Collection of GPS data on physical location: This is part of the questions and will ensure that, the location of respondent interviewed is the actual intended location for the interview.
3. Sampling will make provision for oversampling to take care of an attrition in the course of the survey.
4. Finalize clusters, including specific Enumeration Areas (EAs) to be surveyed and

lists of households per EA.

5. Where necessary we will conduct personal back checking of interviews through the team leaders in the field in the course of data collection. In addition, field team leaders will accompany the data collectors in the field to observe the data collection, otherwise called sit-in interviews. There will be at least one team leader for every 4-6 data collectors.

8.8 Data Transmission

Data collected using the tablets shall be transmitted to online secure surveyCTO servers for storage after all checks are performed by field supervisors. This will make use of internet connections to upload the data. Backup of the data will remain on the encrypted and password-protected tablets until the end of field activities and all the data have been synchronized at which time each tablet will be securely and permanently cleaned.

SurveyCTO servers are password protected to allow access to only authorized users. The Data Manager will be able to login and download the datasets for use using the assigned login details. The data will be downloadable in CSV formats for use and offline storage in secure servers at secured data room at APHRC offices.

8.9 Ethical Considerations

The protocol and data collection instruments will be reviewed for adherence to ethical standards by the AMREF Research Ethics and Scientific Review Committee. Additional approval will be obtained from relevant Ministry of Health and heads of counties, health facilities and departments for permission to collect data. There may be potential risks involved with conducting this study. Adolescent girls will be asked a number of questions that are sensitive in nature, including experiences with access and use of ARH services. Participants will be told during the consent process the nature of the topics that will be discussed and the informed consent process will emphasize the voluntary nature of participation and participants' freedom to leave or to refrain from answering any questions they may not want to answer at any time. Interviewers will be trained how to deal with any distress caused by such questions and to pause before sections dealing with particularly sensitive issues and remind participants of the option to not respond.

8.9.1 Informed Consent/Assent

Informed assent will be sought from all participating adolescents prior to their participation in the study, consent from parents of adolescents and consent from all participating adults. (See Appendix 2 for the consent forms). During the parental consent process, we will clarify that the guardian's role is limited to providing consent for the girl to participate. We will ensure that the guardian understands that s/he and other household members will have no access to information provided by the study participant. This will be done in a language that the participant can understand very well and in very clear, simple and unambiguous terms. The participants will also be informed of the right to abstain from participation in the study or to withdraw consent to participate at any time without reprisal. Interviews with adolescents will be done in a very private setting to avoid interference of parents, and they are advised not to share questions with their parents. According to the Kenya law, the age of consent is 18 years and above [16]. However, for the health facility based study (depth Interview) we will assume that since the adolescents who participate in the study are sexually active and seeking sexual and reproductive health services, we therefore will treat them as emancipated minors and therefore want to ask for waiver of parental consent.

Prospective study participants will be provided with information about the study before any consent to participate is sought. Participants will be adequately informed about the:

- Purpose of the study and methods to be used;
- Institutional affiliation of the research;
- Anticipated benefits and potential risks and follow-up of the study;
- Discomfort it may entail;
- The right to abstain from participating in the study, or to withdraw from it at any time, without reprisal;
- Measures to ensure confidentiality of information provided.

Data collectors will be trained on ethical issues to ensure that guidance on ethical conduct is clearly understood and implemented. Such training will include 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.

For the health facility studies – mystery client surveys and in-depth interviews with providers, consent will be obtained from the clinic heads and the providers themselves. In depth interviews will be conducted with adolescent girls that are already enrolled and

using the ITH platform to access reproductive health services. As such, sampling of adolescent girls will be done in collaboration with ITH implementers, who will thereafter contact sampled respondents directly through established communication channels including direct contact of the girls through mobilizers, project meetings/forums with ITH users or direct phone calls. Adolescent girls that agree to participate in the study will be invited for face to face interviews in venues that will guarantee their privacy. Such venues may include rooms set aside in ITH project site offices, facilities or other appropriate venues that will not expose the respondents. Rooms will be set up to ensure that only one interview takes place at a time, with only the interviewer and respondent present.

8.9.2 Privacy and confidentiality

The privacy and confidentiality of respondents and the information they provide will be strictly observed at all times. Both the quantitative surveys and qualitative interviews will take place in convenient places where privacy and confidentiality of the respondents will be ensured. All raw data will be protected as confidential and availed only to the research team. No uniquely identifying information, such as names, phone numbers, or addresses, will be collected from respondents. Rather, all those interviewed will be identified by a pseudonym. No individuals will be identified in dissemination of the findings or in any report related to this study. Informed consent forms will be retained for some years, after which they will be destroyed.

8.9.3 Ethical Training Certification and Clearance

The protocol has been reviewed by APHRC's internal scientific committee and has been adjudged to be scientifically sound. See Appendix 3 for online ethical training certifications for all the investigators.

8.9.4 Risks and benefits

There is no major risk for participation in the study. We have introduced a series of safeguards and protections for potential risks of privacy and confidentiality and possible distress caused by asking sensitive information. More importantly, the research team will ensure that interviews take place in locations where a reasonable level of privacy is possible, in a separate location or room where other people are not able to overhear the

interviews. Interviewers are advised to end the interview if privacy is not able to be maintained.

However, some of the questions asked in the interview might bring up feelings or make respondents feel uncomfortable. Participation in the interview is entirely voluntary, and respondents may refuse to answer any of the questions and can stop the interview at any time. Training sessions will cover the ethics of sensitive research, confidentiality, and how to address the psychological risks, should they occur. All interviewers will be trained to pause before sections dealing with particularly sensitive issues and remind participants of the option to not respond. They will be advised to refer respondents to local organizations that provide appropriate services to contact if they like to access a counselor or social service. For those respondents under the age of 18, parents will be informed during the consent process the nature and importance of the topics that will be discussed and not to interfere once they consent.

There is no direct benefit to participating in the interview. However, the study findings are expected to contribute important information to policy makers in the Kenyan government and other stakeholders interested in the provision of adolescent friendly SRH information and services.

9. Data Processing and Analysis

9.1 Data Processing

9.1.1 Survey tools programming

This stage is important in ensuring the survey tools are translated into the right electronic versions for data collection. The survey tools shall be programmed using the ODK-based SurveyCTO platform for data collection and management. During programming, consistency checks shall be in-built into the data capture software to ensure that there are no cases of missing or implausible information/values entered into the database by the field interviewers. For example, the application will include controls for variables ranges, skip patterns, duplicated individuals, and intra- and inter-module consistency checks. This will reduce or eliminate errors usually introduced at the data capture stage.

The developed tools shall be deployed onto the APHRC online SurveyCTO account, which is a subscription based account held by APHRC on the SurveyCTO servers. Samsung tablets running Android 5.0 operating systems shall be used to collect the data using the developed tools.

9.1.2. Tools testing and validation

Once programmed, the survey tools shall be tested by the programming team before handing over to the Quality Control team, who in conjunction with the project team will conduct further testing on the application's usability, in-built consistency checks (skips, variable ranges, duplicating individuals etc.), and inter-module consistency checks. Any issues raised shall be documented and tracked on the Issue Tracker and followed up to full and timely resolution. After internal testing is done, the tools shall be available to the project and field teams to perform user acceptance testing (UAT) so as to verify and validate that the electronic platform works exactly as expected, in terms of usability, questions design, checks and skips etc.

9.1.3. Real-time quality check and Data cleaning

Data cleaning is performed to ensure that data are free of errors and that indicators generated from these data are accurate and consistent. This process begins on the first day of data collection as the first records are uploaded into the database. The data manager will use data collected during pilot testing to begin writing scripts in Stata 14 to check the variables in the data in 'real-time'. This ensures the resolutions of any inconsistencies that can be addressed by the data collection teams during the fieldwork activities. The Stata 14 scripts that perform real-time checks and clean data also write to a .rtf file that details every check performed against each variable, any inconsistencies encountered, and all steps that were taken to address these inconsistencies. The .rtf files also report when a variable is found not to have any inconsistencies. The data manager performs all checks according to the flow of the survey tools, instructions in the survey tools and instructions to data collectors in both the survey tools and the data collection manual. The .rtf file that is generated as a result of the real-time checks is sent to the field coordinator for reconciliation of inconsistent data in the field. Audios from qualitative interviews will be transcribed and saved in MS Word format.

9.2 Data Analysis Strategy

9.2.1 Quantitative data management and analysis

Data will be collected by trained interviewers using android tablets with the tool programmed in Open Data Kit (ODK), which will be synchronized on a safe server (already hosted by APHRC) using SurveyCTO. The data collection will be thoroughly supervised, and supervisors conduct spot-check interviews on at least 5% of the sample to verify accuracy of data collected. There will be a careful cleaning of the data on the SurveyCTO platform. In addition to the regular meetings between investigators and field supervisors to monitor data quality, the investigators will make field visits to supervise the overall conduct of the study and ensure that the study protocol is adhered to. Further data checks will be conducted to verify response gaps and data cleaning will be done using STATA software. Quantitative data analysis will be done using STATA, and all relevant descriptive analysis such as percentages, mean, median and standard deviations will be computed based on the objectives of the study. The baseline-endline dataset will be analyzed using standard pre-post data analyses approaches including difference in difference or propensity score matching approaches. Statistical tests of significance will be conducted at 95% confidence interval. At the endline analysis, statistical models will be used to isolate the effects of program-related exposures on behaviour outcomes, controlling for baseline behavior.

All survey data collected in relation to the project will be stored electronically for a period of five years.

9.2.2 Qualitative data management and analysis

With regards to the qualitative study, we use IDI guide, which will be translated into the local language and back-translated into English by two translators working independently, and will be repeatedly checked for accuracy. The tool will be pre-tested by local data collectors by conducting pilot interviews during their training. A facilitator and note-taker will be trained how to use the IDI guide, how to facilitate the interview to elicit the information sought, and how to take detailed notes

All interviews will be tape-recorded and the consent process will include permission to tape-record the session. Audio recordings from the IDIs will be anonymized, labelled with unique identifiers and deleted from digital recorders once transcription is done.

A qualitative software analysis program (NVIVO software) will be used to assist in coding and analyzing the data. A “framework analysis” approach will be used to summarize and analyze the data, and to assist in the development of a codebook and coding scheme. Data will be analyzed by first reading the full FGD transcripts, becoming familiar with the data and noting the themes and concepts that emerge. A thematic framework will be

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

We also use the qualitative findings to triangulate some of the constructs measured through the survey questionnaire – adolescent’s user experience, voice and autonomy. These constructs are also included in the qualitative in-depth interviews with adolescent services users and FES guides to enable triangulation of findings from the adolescent survey.

10. Communication of Study Findings

APHRC will share evaluation findings with the ITH advisory board and will convene adolescent health and SRH stakeholders to share findings and other emerging evidence on what works to improve adolescent outcomes. At the end of phase one evaluation, we propose holding stakeholder meetings to share the findings of the baseline survey and qualitative study findings. At the conclusion of Phase 2, a national stakeholder meeting with representatives from around Kenya will convene in Nairobi for a round-table discussion of learnings from ITH, led by implementing partners and informed by the evaluation. As a culmination of the evaluation, APHRC will work with ITH to facilitate a final strategy session for stakeholders on next steps for action, should the evidence warrant it.

To support these efforts, APHRC will use its strong network of cross-sectoral adolescent health and SRH contacts across Kenya from years of recent implementation research on these topics. We will update and tailor an environmental scan of adolescent SRH actors in collaboration with ITH implementing partners. As a part of its ongoing work to identify and share proven interventions that work for different groups of adolescent girls in Kenya, APHRC expects to work in partnership with the ITH implementing partners, the funder and a broad coalition of other adolescent SRH actors to encourage thoughtful use of the results of the evaluation.

APHRC will develop short, policy-maker friendly case studies for each Phase 1 site and a final briefing paper on the overall successes, challenges and opportunities gleaned from the Phase 2 ITH evaluation that will again weave in other learnings from adolescent SRH interventions so that ITH is presented in the context of complementary efforts. The case study content will be shared as a part of the Phase 2 community fora, via online platforms (partner website and social media), and by hosting a webinar to share findings that may be adaptable to other country contexts.

11. Study Limitations and Risks

The study involves cross-sectional surveys (adolescent survey and mystery client survey) and as a result the data potentially suffers from both recall bias and reporting bias. Some information, such as age of the respondent and age at first sex refer to past events and may be affected by reporting and recall bias. Mystery clients will be interviewed following their clinic visits and it might be difficult for them to recall all their experience during the service visit.

In this study Hawthorne effect may occur if the participants modify their behavior or an aspect of their behaviour which is being studied as a result of the knowledge that they are being studied. For instance, the service providers may change their way of delivering SRH services as a result of the knowledge that they are being studied during the intervention period. In the event that the service providers revert back to the old ways of service delivery prior to the intervention by the end of the intervention period, then we may assume that the initial change in the way SRH services delivery was being done was as a result of the knowledge that they were being studied.

Some interviews might be conducted in local languages and later translated in English. This may affect the accuracy of the responses provided by participants, translation bias. However, this will be mitigated by translating the study tools to Swahili with the help of data collectors knowledgeable in local languages that are mainly used in the study sites. Swahili is Kenya's national language and most widely spoken. In addition, intensive training of field interviewers will help mitigate this.

12. Management and Organization of the Study

The study will be implemented and managed by a team of researchers at the African Population and Health Research Center (APHRC). APHRC's study team oversee the study design, the recruitment and training of data collectors, data collection, data quality management and data analysis. All team members participating in the data collection will be trained in research ethics and documentation provided to the IRB. Data collection team will be recruited and trained on the specifics of the study's goal, objectives, and research methods, and will also review key concepts of research ethics. Skills and expertise of data collectors will include: experience with data collection, experience using

electronic devices for data capture and in-depth knowledge of the cultural context in the survey area.

The study will be implemented by the following:

1. Yohannes Dibaba Wado, PhD. Yohannes is a Post-doctoral Research Scientist with African Population and Health Research Center (APHRC). Yohannes has led several research and evaluation studies including studies on adolescent health. Before joining APHRC, Yohannes served as Senior Advisor for Research and Evaluation for Ipas programs in Ethiopia for two and half years.
2. Damazo Kadengye, PhD. Damazo is Associate Research Scientist with African Population and Health Research Center (APHRC).
3. Estelle M. Sidze, PhD. Estelle is an Associate Research Scientist with African Population and Health Research Center (APHRC).
4. Tizta Tilahun, PhD. Tizta is a Post-doctoral Research Scientist with African Population and Health Research Center (APHRC).
5. Joan Njagi, MSC. Joan is a Research Officer with African Population and Health Research Center (APHRC).
6. Clement Oduor, M.A. Clement is a Research Officer with African Population and Health Research Center (APHRC).

13. Work plan

Activities	2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Consultation meetings with implementation partners	x											
Final evaluation plan and data collection Instruments	x	x										
Internal and external ethical approvals from relevant authorities/IRB		x	x									
Adolescent Consultative forums		x	x									
Recruitment and training of Interviewers			x									
Round 1 data collection– survey of adolescents, FES with adolescents and FGD with the community			x									
Light Touch Assessment of Phase 1			x									
First round data analysis and report				x	x							
Internal and external dissemination of baseline findings					x							

Round 2 data collection – IDIs with service providers, FGD with Mobilizers and mystery client survey						x						
Second round data collection report								x	x			
Internal and external dissemination of midline study findings									x			
Round 3 data collection - Qualitative study with community, and end line survey with adolescents										x		
Data Analysis											x	
Stakeholder Meeting & Research Uptake												x
Report, technical briefs and factsheets												x

14. Budget Summary

The study will be implemented for a budget of USD 395,398.62 (Kshs 39,935,626.98) as indicated in **Appendix 5**.

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