



## **Evaluation of the In Their Hands (ITH) Programme**

**Report of a baseline assessment from Homa Bay and Narok Counties**

**African Population and Health Research Center**

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## Executive Summary

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 promotes adolescents' use of contraception and testing for sexually transmitted infections (STIs) including HIV and pregnancy; provides information, products and services on the adolescent girl's terms; and promotes community support for girls and boys to access SRH services. The program is being implemented in 18 counties which have high levels of teenage pregnancy, unmet need for contraception and adolescent vulnerability to HIV infection. This study was conducted to provide baseline information on key areas of interest to the ITH project, including adolescent's access to SRH information and services, sexual behavior, utilization of SRH services and quality of care, as well as community perceptions of adolescent SRH.

The study was conducted in two counties – Homa Bay and Narok – selected purposively from the eighteen intervention counties for the baseline study. The study employed a mixed-methods approach – qualitative and quantitative data were collected from adolescents, parents and community health volunteers in the two counties. The survey included a total of 1,840 adolescent girls aged 15-19 years old. Moreover, 12 focus group discussions (FGDs) with parents and community health volunteers (CHVs) and 45 in-depth interviews (IDIs) were conducted with adolescent girls. In the selected counties and sub-counties, samples were drawn from wards and villages closer to health facilities selected for the ITH intervention. Data were collected by trained female interviewers. The survey tools were programmed using ODK-based SurveyCTO platform for data collection and management. Data was analyzed using STATA to provide descriptive statistics on key study questions. Qualitative data was audio-recorded with permission, transcribed verbatim and translated to English. 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.

The survey with adolescents indicated that quite a large proportion of adolescent respondents received information on sexual and reproductive health issues (about reproductive physiology, how pregnancy occurs and how pregnancy as well as STIs/HIV can be prevented) in the 12 months before the survey. They received this information mainly from teachers, friends and the media. Other sources of information were health facilities, community health volunteers and parents, albeit for a lower proportion of respondents. Majority of the respondents have access to media sources such as television and radio but only one-third of adolescents reported owning a mobile phone.

Knowledge of any contraceptive method is almost universal among the respondents. The most commonly known contraceptive methods by adolescents in the two counties are the male condom, injectables and implants. On the other hand, methods like the IUD, female condom and emergency contraception are known by a smaller proportion of respondents. In addition, correct knowledge of the fertile period is quite low reflecting gaps in the understanding of when pregnancy may occur during a given menstrual cycle. However, knowledge of correct methods of preventing sexually transmitted infections (STIs) and HIV/AIDS is high, with nearly two-third of adolescents in both counties reporting condom use and abstinence as the main

mechanisms to prevent STIs. Data on adolescent decision making on issues of sexuality and contraceptive use shows that adolescents reported good levels of confidence in their ability to negotiate condom use or contraceptives with their boyfriends and partners as well as confidence in asking a health provider questions about contraceptive methods and in discussing STIs/HIV and pregnancy-related issues. The majority of adolescents also provided affirmative responses to the items on self-esteem, social networks and voice although a relatively lower proportion of adolescents reported participating in key household decisions.

Early sexual debut is common in the two counties. While the majority of the respondents in both counties had engaged in sex before 19, nearly half were sexually active in the twelve months before the survey. About 40% of girls in Homa Bay and 29% of girls in Narok have engaged in sex by age 14. Multiple sexual partnerships is also a common issue with 46% and 52% of sexually active respondents in Homa Bay and Narok reporting having had sex with two or more sexual partners in their lifetime. As the two counties have higher HIV prevalence rates, there is a need to provide tailored information on the dangers of multiple sexual partnerships and the use of condoms for preventing HIV/STI infections. Early marriage is also common, particularly in Narok where 26% of respondents were married at the time of the survey. As a result, pregnancy rates are relatively high in both counties compared to the national level. In the qualitative study, adolescents reported that ‘tricks’ used by boys in romantic relationships, failure of natural contraceptive methods such as standard days method, lack of proper counselling on pregnancy prevention and adolescent-friendly services contribute to the high level of pregnancy in the counties. More than two-thirds of adolescents who had ever been pregnant reported that their pregnancy was either mistimed or not wanted at all.

The contraceptive prevalence rate (CPR) – any method – among all respondents was 37% in Homa Bay and 21% in Narok. These CPR levels are relatively high compared to results reported by the 2014 Kenya Demographic and Health Survey (10%). Contraceptive use is relatively higher among sexually active adolescents particularly in Homa Bay where nearly 60% of sexually active adolescents reported using any method, compared to only 36% in Narok. The findings show that most adolescents use condoms, contributing to the relatively high CPR in both counties. However, this is not necessarily the most effective method for pregnancy prevention although it does offer dual HIV and pregnancy protection. The majority of adolescents who used contraceptives obtained them from public facilities and they rated the quality of care to be fairly good. Qualitative data highlighted misconceptions regarding contraceptives and their utilization that could explain the high levels of condom use. Modern contraceptive methods such as injectables or hormonal methods are seen as contributing to infertility if used before child bearing. These contraceptive methods are considered to be for married woman, not for children/adolescents.

The majority of adolescents who sought SRH services visited public facilities. Overall, about 41% of respondents in Homa Bay and 30% in Narok visited health facilities in the 12 months before the survey, largely for HIV and STI testing, family planning and antenatal care. Respondents were asked about the perceived barriers they face in accessing SRH services. A considerable proportion of them mentioned ‘concern that there may not be a friendly and respectful service provider’, ‘getting money for treatment’ and ‘concern that there may not be a provider available’ as key barriers to accessing SRH services. In the qualitative interviews, adolescents voiced concerns about unaffordability of contraceptives which cost 200-500 Kenyan shillings, lack of adequate information, overstretched health personnel and long queues at health facilities, poor attitudes of healthcare personnel, and lack of adolescent-friendly services. However, most of the adolescent girls

interviewed were generally satisfied with the quality of services received at health facilities, especially with the health facility aspects such as availability of adequate space and waiting areas, operational hours, and convenience. Youth-friendly dimensions such as having a friend or another person with them when receiving the service and allocation of suitable appointments for young people were mentioned as areas for improvement.

The qualitative study indicated that there is inadequate parental involvement and support for the SRH challenges faced by adolescents. Parents consider issues of sex and romantic relationships as dangerous, and discussions between parents and adolescent girls tend to have a strong focus on abstinence. Parents attributed the gap in discussing SRH issues with adolescent girls to lack of parental skills to discuss such issues and the taboo nature of sexual matters whose discussions lead to discomfort. There is also the belief that unmarried adolescents should not use contraception as it is believed to cause infertility and other diseases.

The findings highlight the need to provide more tailored and age appropriate information and education on adolescent sexual and reproductive health issues, including information on the safety and effectiveness of contraception, timing of the fertile period and availability of free adolescent-friendly SRH services. At facilities, there is a need to improve contraceptive counselling and offer a wider mix of contraceptive methods for adolescents. Concerns about side effects as well as myths and misconceptions about contraceptives should be improved by better counselling. Parental involvement and communication on adolescent SRH is critical and thus should be promoted as part of adolescent SRH programs. It is also essential to design strategies to reach underserved and rural areas in each of the counties as disparities in the use of SRH services is remarkable, varying with residence, education, and county. In counties such as Narok, very few facilities are selected for ITH intervention. These facilities are located in fewer towns within the county which means the larger proportion of widely dispersed, rural adolescents are out of reach.



## 1.0 Introduction

### 1.1 Background

Evidence exists to show that adolescents in developing countries are more vulnerable to early and unintended pregnancies and unsafe abortion due to poor access to sexual and reproductive health (SRH) information and services, early sexual debut, early marriage and poverty among other factors [1, 2]. Each year an estimated 21 million pregnancies occur among adolescent girls aged 15-19 years in developing countries, almost half of which (49%) are unintended [3, 4]. This results in an 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]. Majority of girls who report ever being pregnant are out of school and this contributes to lower educational attainment and to a cycle of poverty, as teenage mothers are not able to fully participate in the labor force or acquire greater social capital to be fully involved in their respective communities [9]. 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].

Contraceptive use has improved among married and sexually active young women in Kenya in the last few decades but 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 [1]. Sexually active unmarried adolescents have the highest unmet need for contraception [5]. The reasons for low contraceptive uptake among adolescents are complex and include lack of agency and control over their lives, lack of access to reliable sources of contraception information and inadequate financial resources. Broader socio-economic factors such as poverty, lack of education and limited economic opportunities among girls may also contribute to adolescent pregnancy [10, 11]. Socio-cultural and gender norms that promote early marriage and childbearing, as well as 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 healthcare, including provider bias, age restrictions or stigmatization when seeking services in addition to 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 healthcare providers [1, 8].

Existing evidence shows that sexual and reproductive health education, counselling and contraception provision are effective in increasing adolescents' knowledge, contraceptive use and decreasing adolescent pregnancy [2, 9, 13]. In addition, the potential of several strategies 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 implemented to reduce teenage pregnancy and associated challenges in different parts of the world. Moreover, the involvement of key community gatekeepers such as parents and religious leaders is vital to generating wider community support and increasing contraceptive use among adolescents [14]. Thus, 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.

In response to the prevailing high level of teenage pregnancies, Kenya's Ministry of Health revised the National Adolescent Sexual and Reproductive Health Policy in 2015 to provide guidance to government ministries and development partners on how to respond to the SRH needs of adolescents. The policy aims to enhance the SRH status of adolescents in Kenya and contribute towards realization of their full potential in national development [10]. The In Their Hands (ITH) program, supported by Children Investment Fund Foundation (CIFF), aims to increase adolescents' use of high-quality sexual and reproductive health (SRH) services through targeted interventions. The program objectives are threefold, namely: (1) to get adolescents to want contraception and to know whether 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 access to SRH services.

The African Population and Health Research Center (APHRC) is conducting an independent impact evaluation of the ITH program. 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; (2) improving community support for adolescent SRH in Kenya, and, (3) if and how the ITH partnership model and integrated system of delivery is meeting its intended objectives and the needs of adolescents, strengthens the voice of adolescents and their decision-making autonomy.

## **1.2 Objectives of the baseline assessment**

The aim of the baseline study was to provide baseline information on key aspects of the ITH intervention; adolescents' access to SRH information and services; experience with SRH services and quality of care and community perceptions and support for adolescent SRH in the two intervention counties. The specific objectives of the baseline study include:

- Assess adolescent access to SRH information and services
- Document adolescent SRH behavior and outcomes
- Assess adolescent SRH user experience and quality of care
- Assess adolescents' decision making autonomy, social networks and voice on matters related to sex and relationships
- Assess community perceptions on adolescent SRH and their support for adolescent SRH initiatives

## **2.0 Evaluation design and methodology**

### **2.1 Evaluation design**

The evaluation uses mixed methods design including a before and after intervention design to systematically assess the delivery, effectiveness and effects of the program. It incorporates routinely collected program monitoring data and additional data collection to fill the gaps and to complement the ITH monitoring data. For this baseline study, we conducted a cross-sectional study with both qualitative and quantitative components in the counties of Homa Bay and Narok located in the former Nyanza and Rift Valley provinces respectively. We conducted qualitative studies with adolescents, community members and community health volunteers in addition to cross-sectional surveys with randomly sampled adolescent girls aged 15-19 years in the two counties.

### **2.2 Study sites**

The ITH project is implemented in eighteen counties in Kenya with most counties concentrated in Nyanza, Rift Valley and Western regions. It is being implemented in all the six counties of Nyanza (Kisumu, Migori, Kisii, Siaya, Nyamira, and Homa Bay). In Rift Valley, the project is being implemented in Kericho, Trans Nzoia, Kajiado, Narok and Nakuru counties. These 18 counties were prioritized based on their high level of teenage pregnancy, high unmet need for contraception among adolescents and high rates of new STI and HIV infections. For the purpose of the evaluation, we purposively selected two counties from the counties where ITH intervention had not begun at the time of the baseline study – one from Nyanza (Homa Bay) and another from Rift Valley (Narok). The selection of the counties also considered other important criteria including availability of other similar interventions on adolescent sexual and reproductive health, as well as geographic and socio-economic similarities with the counties where the project is being implemented.

#### **Contexts of the selected counties**

Homa Bay County is located in South Western Kenya along Lake Victoria where it borders Kisumu and Siaya counties to the north, Kisii and Nyamira counties to the east, Migori County to the south and Lake Victoria and the Republic of Uganda to the west. Administratively, Homa Bay County is divided into eight sub-counties. According to the 2009 Kenya Population and Housing Census, the county has a population of 963,794 persons consisting of 462,450 males and 501,344 females. Homa Bay County covers an area of 3183.29 km<sup>2</sup> with a population density of 302.77 people/km<sup>2</sup>. According to the 2014 KDHS, the county has one of the highest teenage pregnancy rates in the country at 33%, only second to Narok county (40.4%). Overall, the county has a high fertility rate and child bearing starts early. The 2014 KDHS showed that women in the county give birth to an average of 5.2 children while the national average was 3.9 in 2014 [5]. At 17.6 years, Homa Bay County has one of the lowest median age at first birth among women aged 25-49 years. On the other hand contraceptive use is one of the lowest in the country. In 2014, only 46.7% of married women in Homa Bay used any form of family planning, which was much lower compared to the national average of 58% [5]. Contraceptive use among adolescents was much lower nationally with only 10% of all adolescents girls aged 15-19 years using

contraception at the time of the survey [5]. The Nyanza region also has one of the highest levels of unmet need for contraception (23.2%) in Kenya after the North Eastern region (29.9%).

Narok County is located in the southern part of the Rift Valley. Administratively, Narok is divided into six sub-counties. According to the 2009 Kenya Population and Housing Census, Narok has a population of 850,920 people, 428,976 males and 421,894 females. The county covers an area 17,923 km<sup>2</sup> with a population density of 47.45 people/km<sup>2</sup>. According to the 2014 KDHS, the county has the highest teenage pregnancy in the country at 40.4%. The county also has a high fertility rate and child bearing starts early due to early marriage practices. The 2014 KDHS showed that women in the county give birth to an average of 6.0 children while the national average was 3.9 in 2014 [5]. The median age at first birth was 19.0 years compared to the national average of 20.3 years in 2014. On the other hand contraceptive use is one of the lowest in the country. In 2014, only 47.8% of married women in Narok used any form of family planning, which was much lower compared to the national average of 58% [5]. The Rift Valley region also has one of the highest levels of unmet need for contraception (20.8%) in Kenya.

## **2.3 Qualitative data collection**

Qualitative studies were used to assess adolescent perceptions and experiences with SRH issues and challenges, decision-making autonomy and community support for adolescent SRH. For this purpose, in-depth interviews (IDIs) were conducted with adolescents in Homa Bay and Narok counties, and focus group discussions (FGDs) with caretakers and community health volunteers. IDIs were conducted with a small number of adolescent girls who participated in the adolescent survey to identify adolescent girls' SRH concerns, how they addressed SRH concerns, community support for SRH issues, barriers to accessing the SRH services, as well as their perspectives on how the barriers can be addressed at the community level and at the facility level. The FGDs with the community (caretakers and parents) and community health volunteers (CHVs) were used to explore the community's attitudes towards adolescent sexuality and their support for adolescents' reproductive health services. Participants were invited to the FGDs if they had adolescent girls of age 15-19 years. Moreover FGDs were conducted with community health volunteers in the two counties.

### **2.3.1 Qualitative sampling**

Participants in the focus group discussions were recruited from the villages where the ITH adolescent household survey was conducted in both counties. A convenience sample of consenting adults living in the villages were invited to participate in the FGDS. A facilitator and note-taker were trained on how to use the focus group guide, how to facilitate the group discussions to elicit the information sought, and how to take detailed notes. All focus group discussions took place in the local language and were audio-recorded. The consent process included permission to audio-record the session. Participants were identified only by their first names and were asked not to share what was discussed outside of the focus group. An informed consent form was read out to participants and they were asked to give their written consent.

In-depth interviews were conducted with purposively selected samples of consenting adolescent girls who participated in the adolescent survey. We conducted a total of 45 in-depth interviews with adolescent girls (20 in Homa Bay County and 25 in Narok County respectively). In addition, eight FGDs (four per county) were conducted with mothers of adolescent girls who are usual residents of the villages which had been identified for the interviews and another four FGDs (two per county) with CHVs.

### **2.3.2 Qualitative tools**

The qualitative interview guides included IDI guides for adolescent girls and FGD guides for mothers of adolescents and community health volunteers respectively. The in-depth interview and focus group discussion guides were developed in English and then translated into 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 during their training.

All the qualitative tools were piloted on a small sample of adolescent girls for in-depth interviews with adolescent girls aged 15-19 years. They were also tested on mothers of adolescent girls and CHVs for their respective FGDs before the start of the main study. The guides were administered through face to face interviews. The interviews were held individually for the adolescent girls, and in groups for mothers and CHVs.

### **2.3.3 Qualitative data management and analysis**

All interviews were audio-recorded and the consent process included permission to audio-record the session. Audio recordings from the IDIs were anonymized, labelled with unique identifiers and deleted from digital recorders once transcription was done. 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 FGD 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. We also used the qualitative findings to triangulate some of the constructs measured through the survey questionnaire – adolescents’ decision making, voice and quality of SRH services among others. These constructs were also included in the qualitative in-depth interviews with adolescent services users to enable triangulation of findings from the adolescent survey.

## **2.4 Quantitative data collection**

The quantitative study involved a community based cross-sectional survey with adolescents aged 15-19 years in the two counties to establish baseline information for the intermediate outcomes of the project; how ITH

had changed adolescent access to information, healthcare services use and decision making autonomy. We conducted a survey among a representative sample of adolescent girls living in both urban and rural areas to understand adolescents' access to information, use of SRH services and SRH-related decision making autonomy.

### **2.4.1 Sampling and sample determination**

The sampling of adolescents for the household survey was 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 was used as a baseline proportion for the intervention as it aimed to increase demand and reduce the proportion of sexually active adolescents who did not intend to use contraception in the future. Assuming that the project was to 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 **1,885** was estimated using Cochran's sample size formula for categorical data as being adequate to detect this difference between baseline and end-line time points. Based on data from the 2009 Kenya Census, there were approximately 0.46 adolescent girls per household, which meant that the study was to include approximately **4,876** households from the two counties at both baseline and end-line surveys.

We collected data among a representative sample of adolescent girls living in both urban and rural ITH areas to understand adolescents' access to information, use of SRH services and SRH-related decision making autonomy before implementation of the intervention. Depending on the number of ITH health facilities in the two study counties, we sampled 3 sub-Counties from each county. West Kasipul, Ndhiwa and Kasipul; and Narok, Narok Town, Narok South and Narok East purposively. In each of the ITH intervention counties, there were sub-counties that had been prioritized for the project and our data collection focused on the sub-counties selected for intervention. A stratified sampling procedure was used to select wards within the sub-counties and then select villages from the wards. Households were then selected from each village after all households in the villages were listed. The purposive selection of sub-counties closer to ITH intervention facilities meant that urban and semi-urban areas were oversampled due to the concentration of health facilities in urban areas.

### **2.4.2 Inclusion and exclusion criteria**

The adolescent survey included participants from both rural and urban areas in the two selected implementation counties. The inclusion criteria were:

- Adolescent girls aged between 15-19 years
- Resident in the study areas for at least six months preceding the study
- Members of the sampled households in the study counties located in either of the intervention counties

On the other hand, exclusion criteria of age, non-residence in the study areas, and not living in the sampled households for at least six months prior to start of the study were applied. Accordingly, students who stay in boarding schools away from their parents were excluded from the study.

### **2.4.3 Data collection procedures**

#### **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 household 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 two counties sampled for the study. A team of 24 data collectors (21 quantitative and 3 qualitative) were recruited and trained at the APHRC Campus in 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 ready would proceed to the field. Further, team leaders were identified from the team based on performance and demonstrated leadership skills.

#### **Pilot test**

A pilot test was done in Korogocho slum. During the pilot, the study management team was with the data collection team in the field to help observe and support the data collectors in case they encountered any problem with the devices and the survey tools. Each field interviewer conducted two interviews including with eligible adolescent girls aged 15-19 years for both quantitative and qualitative interviews. In addition, mothers of adolescent girls aged 15-19 and CHVs were also purposively sampled for respective FGDs. Data from the pilot was then assessed to help identify areas that needed to be addressed prior to the 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. Piloting would also test the quality of the tool as programmed in SurveyCTO, as well as inform survey planning and organization. A debrief meeting was held after the pilot to share experiences and challenges that the data collection team were able to identify during the data collection. These concerns and challenges were reviewed and necessary revisions made to the tools and the software before the main survey.

#### **2.4.4 Data collection**

Data for the survey was collected from September 1, 2018 to October 12, 2018. The field team was provided with a list of sub-counties, wards and ITH health facilities in the sub-counties sampled for the study in both Narok and Homa Bay counties. Face-to-face quantitative interviews were conducted with eligible adolescent girls once the household heads had consented to their households participating in the study. Informed parent/guardian consent forms were provided in hard copy for parents/guardians whose adolescent girls were under 18 years old. Adolescent girl participants aged 18-19 years certified their consent by signing a soft copy consent programmed on the SurveyCTO in the tablets. In addition, face-to-face in-depth interviews were conducted with adolescent girls aged 15-19 years as well as focus group discussions with CHVs and mothers of 15-19 year old adolescent girls.

The data collection teams worked closely with the local leaders (area chiefs, assistant chiefs, village elders) and community health volunteers attached to the health facilities to identify study boundaries and mobilize study participants. After establishing the boundaries, quantitative field interviewers visited each household within the boundaries of the selected ward/village and provided information about the study to the household heads. The interviewers sought their permission and consent to be part of the study by participating in the household listing.

Team leaders and field supervisors had daily debrief meetings with the teams and were able to work with their respective teams at the end of each day to review all completed interviews for any errors before being approved for synchronization into the main servers at the APHRC office. Any errors, such as incorrectly filled forms, missing data and inconsistencies detected would be referred back to the field for correction as necessary before being approved for synchronization. In addition, the team members used these meetings to share their daily experiences which they would then compile and share with the study management team and the rest of the survey team for action, if necessary.

In the case of qualitative interviews, the field interviewers worked with community leaders such as village elders and CHVs to mobilize qualitative study respondents for both in-depth interviews and FGDs

#### **2.4.5 Quantitative tool**

The questionnaire covered: 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; voice and decision making autonomy and quality of care for those who visited health facilities in the 12 months before the survey. The questionnaire was piloted before data collection and the questions reviewed for appropriateness, comprehension and flow. The questionnaire was piloted among a sample of 42 adolescent girls (two per field interviewer) aged 15-19 years from a community outside the study counties.



The questionnaire was originally developed in English and later translated into Kiswahili. The questionnaire was programmed using ODK-based SurveyCTO platform for data collection and management and was administered through face-to-face interviews.

#### Data quality control activities in the field

Several data quality control approaches were used during data collection. These included:

- i. Reviews of each questionnaire by the field interviewers before leaving the household to be sure that every applicable question had been asked and that responses recorded were clear and reasonable.
- ii. Team leaders and supervisors conducted sit-in interviews with their team members to randomly observe each interviewer at least once per week during the survey implementation. This helped to verify that field interviewers were following all the procedures outlined in the training and to ensure that interviews were being conducted to the highest standards.
- iii. The team leaders also conducted spot checks on randomly selected interviews to verify that the field interviewers went to the right households and asked the right questions.
- iv. All completed interviews were reviewed by the team leaders to ensure their internal consistency and completeness.
- v. In-built internal consistency checks were embedded in the SurveyCTO platform, and error messages and caution notices were triggered when out of range data were entered to alert field interviewers to correct the errors.
- vi. Data inconsistency check reports based on pre-designed data quality check scripts were generated daily by the data manager for the study. Daily feedback was provided to the field teams for validation and correction as needed.

#### **2.4.6 Data transmission**

Once completed interviews were reviewed by the team leaders and confirmed to have no issues requiring correction, the data was approved for synchronization. Data in the tablets was transmitted to an online secure SurveyCTO server at the APHRC office. The transmission relied on internet connections to enable the data to be uploaded. Backup versions of the data remained in the encrypted and password-protected tablets until the end of field activities when all the data would have been synchronized. Subsequently, each tablet was securely and permanently cleaned. SurveyCTO servers are password protected to allow access to only authorized users. Only the data manager is able to login and download the datasets for use using the assigned login details. The data would be downloaded in CSV format for use and offline storage in secure servers located inside a secured data room at the APHRC Campus.

## **2.5 Data processing and analysis**

### **2.5.1 Data processing**

The survey tools were programmed using the ODK-based SurveyCTO platform for data collection and management. During programming, consistency checks were built into the data capture software which ensured that there were no cases of missing or implausible information/values entered into the database by the field interviewers. For example, the application included controls for variable ranges, skip patterns, duplicated individuals, and intra- and inter-module consistency checks. This reduced or eliminated errors usually introduced at the data capture stage. Once programmed, the survey tools were tested by the programming team who in conjunction with the project team conducted 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 were documented and tracked on the Issue Tracker and followed up to full and timely resolution. After internal testing was done, the tools were availed to the project and field teams to perform user acceptance testing (UAT) so as to verify and validate that the electronic platform worked exactly as expected, in terms of usability, question design, checks and skips, etc.

Data cleaning was performed to ensure that data were free of errors and that indicators generated from these data were accurate and consistent. This process began on the first day of data collection as the first records were uploaded into the database. The data manager used data collected during pilot testing to begin writing scripts in STATA 14 to check the data variables in 'real-time'. This ensured the resolution of any inconsistencies that could be addressed by the data collection teams during the fieldwork activities. Audio recordings from qualitative interviews were transcribed and saved in MS Word format.

## **2.6 Quantitative data analysis**

In addition to the careful cleaning of the data on the SurveyCTO platform, further data checks and cleaning were conducted using STATA software to verify response gaps. Data analysis was performed using STATA 14, and all relevant descriptive analysis such as percentages, mean, median and standard deviations was computed based on the objectives of the study. The results were presented in the form of graphs and tables.

## **2.7 Response rate**

A total of 1,897 households with eligible respondents were identified through the household listing done in all the sampled villages (46). We sampled only one eligible girl per household. However, only 1,840 adolescent girls were successfully interviewed for the study. Consent for the remaining 57 adolescent girls was not provided mainly due to their unavailability. This resulted in an overall response rate of 97%. Cases of non-responsiveness were attributable to girls' refusal to participate or their unavailability even after repeated visits and callbacks.

**Table 1: Number of interviews done by county, by area and by interview result**

Interview Result	Homa Bay			Narok			Total n(%)
	Urban n (%)	Rural n(%)	Total n(%)	Urban n(%)	Rural n(%)	Total n(%)	
Completed interview	441(94.6)	619(95.2)	1061(95.0)	343(99.7)	434(99.3)	779(99.5)	1840(96.8)
Incomplete interview	0(0.0)	2(0.3)	2(0.0)	1(0.3)	0(0)	1(0.1)	3(0.2)
Not willing to be interviewed	1(0.2)	3(0.5)	4(0.0)	0(0)	1(0.2)	1(0.1)	5(0.3)
Other (call backs unsuccessful)	24(5.2)	26(4.0)	50(4.5)	0(0.0)	2(0.5)	2(0)	52(2.7)
Total	466(100)	650(100)	1116(100)	344(100)	437(100)	781(100)	1897(100)

## 2.8 Ethical considerations

The study protocol was reviewed by APHRC’s internal scientific and ethics committee and adjudged to be scientifically sound. Thereafter, the protocol and data collection instruments were reviewed for adherence to ethical standards by the AMREF Research Ethics and Scientific Review Committee. Research clearance for the study was granted by Kenya’s National Commission for Science, Technology and Innovation (NACOSTI). Additional approval was obtained from county and sub-county commissioners, Ministries of Health and Education in the respective study counties; and other local administrators such as Chiefs, Assistant Chiefs and Village Elders for permission to collect data in their respective areas.

Furthermore, 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. For adolescents who were 18-19 years old or emancipated minors, individual consent was sought. Otherwise, both parental/guardian consent and children’s assent were obtained before starting interviews.

Data collectors were trained on ethical issues to ensure that guidance on ethical conduct was clearly understood and implemented. Such 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.

## 2.9 Challenges during fieldwork and possible mitigation

Some of the challenges encountered during data collection and related mitigation measures included:

- i. Data collection period overlapping with school calendar. While the study deliberately excluded adolescent girls in boarding schools, most of the girls aged 15-19 years targeted in the study were going to school and were not easily available during normal working hours. The data collection team worked late hours to help make contact even with those who were being released late from school. In addition, the team worked during weekends and public holidays.
- ii. Sparsely populated areas of Narok meant that the field teams had to walk long distances trying to locate households, especially where the terrain was rough and with impassable roads.
- iii. Negative perceptions about the study arising from sociocultural factors. In Narok county, there was marked resistance to the study, mostly in the rural areas as most residents were very suspicious of the study. They claimed that the study planned to introduce their girls to practices that they do not approve of. In such cases, even household listing could not be undertaken. To mitigate this, the field team was always accompanied by local leaders to help confirm acceptance of the study even by the relevant authorities.
- iv. Language barrier. This was mainly in Narok County where we failed to get enough applicants to join the team. Where there was no Masai speaker, such interviews could not be completed. For qualitative interviews specifically, we had Masai and Luo speakers as part of the qualitative team to allow the interviews to be conducted in the language in which the respondent or most respondents were comfortable with.

## 3.0 Results

### 3.1 Sociodemographic characteristics of respondents

The ITH baseline survey included a total of 1,840 adolescent girls of age 15-19 from Homa Bay (1,061) and Narok (779) counties. This is equivalent to a response rate of 97%. Results show that respondents from Homa Bay were slightly younger (mean age, 16.9 years) than those from Narok (mean age, 17.1 years). Regarding religion, the majority of the respondents in both counties were Protestant Christians. Most respondents (97.5%) from Homa Bay were Luo by ethnicity, while nearly half of the respondents from Narok (48.3%) were Masai. Although the majority of the respondents from both counties (59% from Homa Bay; 56% from Narok) resided in rural areas, urban adolescents were relatively oversampled in comparison to the actual rural-urban distribution of the two counties because the study was conducted in areas closer to health facilities that are part of the ITH intervention. Table 2; and figures 1 and 2 below presents the socio-demographic characteristics of the respondents by county.

**Table 2: Sociodemographic characteristics of the adolescent girls by county**

Characteristic	Homa Bay n(%)	Narok n(%)
<b>Current age in years</b>		
15-17	600 (56.6)	386 (49.6)
18-19	461 (42.5)	393 (50.5)
Mean age	16.9 ( $\pm$ 1.5)	17.1 ( $\pm$ 1.6)
<b>Residence</b>		
Urban	441 (41.6)	344 (44.2)
Rural	620 (58.4)	435 (55.8)
<b>Highest level of Education</b>		
Never attended school	3 (-)	25 (3.2)
Some /completed primary	565 (53.3)	460 (59.2)
Some/completed secondary	477 (45.0)	272 (35.0)
Beyond secondary/vocational	16 (1.5)	20 (2.6)
<b>School attendance</b>		
Attending	696 (65.8)	414 (55.1)
Not attending	362 (34.2)	338 (45.0)
<b>Ethnicity</b>		
Kikuyu	1 (-)	130 (16.7)
Luo	1034 (97.5)	43 (5.5)
Kisii	10 (0.9)	68 (8.7)
Masaai	1 (-)	376 (48.3)
Kalenjin	2 (-)	107 (13.7)
Other	13 (1.2)	55 (7.1)
<b>Religion</b>		
Roman Catholic	213 (20.1)	176 (22.6)
Protestant/other Christian	825 (77.8)	592 (76.0)
Islam	11 (1.0)	3 (-)

Other	12 (1.1)	8 (-)
<b>Ever worked to earn income</b>		
Yes	152 (14.3)	236 (30.3)
No	909 (85.7)	543 (69.7)

- Percentages not calculated for fewer cases (frequencies less than 10).

Majority of the respondents from both counties have attained some primary level of education while about 45% of respondents from Homa Bay and 35% from Narok had secondary or higher level of education. Since the majority of the adolescents are still in school, a relatively small proportion of adolescents (14.3% in Homa Bay; 30.3% in Narok) have been engaged in paid work to earn money (Table 1).

Nearly 66% of the respondents from Homa Bay and 55% from Narok were attending school at the time of the survey (Table 1). In both counties, younger adolescents (ages 15-17) were more likely to be attending school compared to their older counterparts, aged 18-19 years (Figure 1). The major reasons given for not attending school in both counties included parental inability to pay school fees, pregnancy and marriage. About 41% of respondents not attending school from Homa Bay and 26% from Narok reported that they dropped out of school due to pregnancy or birth of a child. Another 24.6% from Narok and 19.6% from Homa Bay reported that they discontinued school due to marriage (Figure 2).

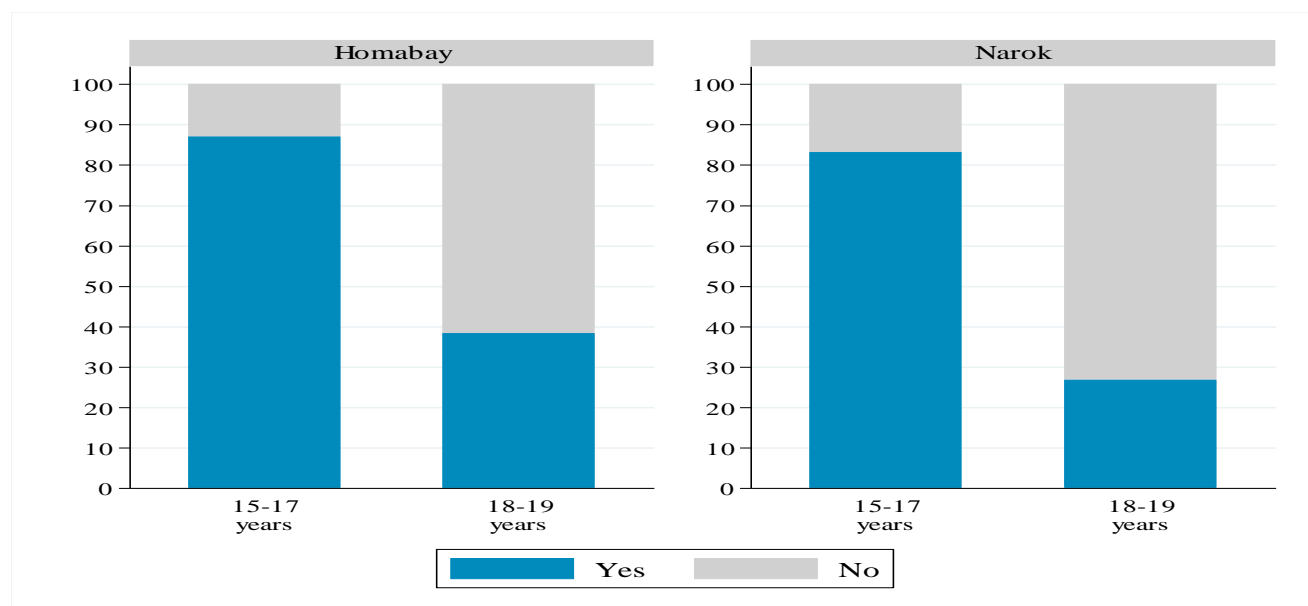


Figure 1: Current school attendance by age group and county

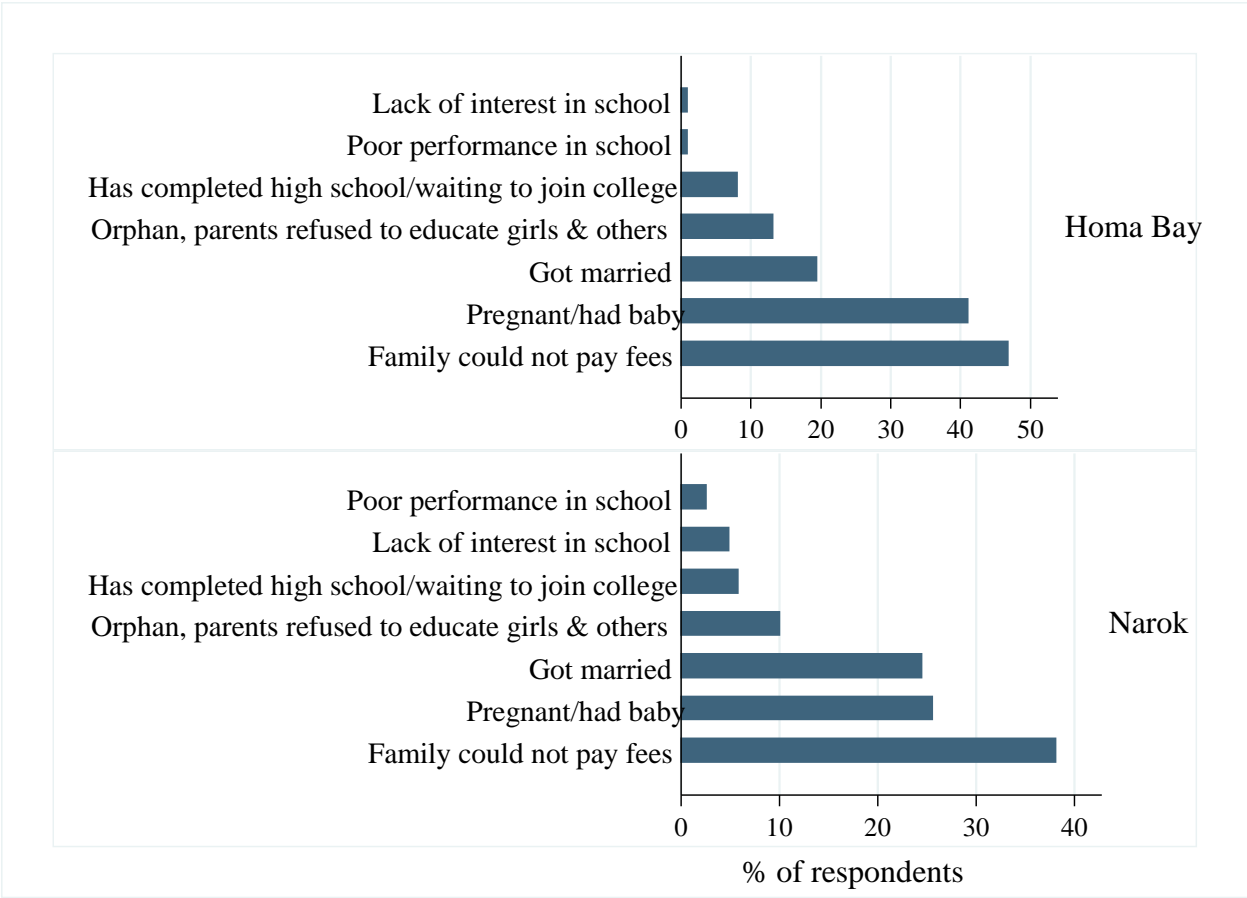


Fig 2: Reasons for not attending school currently

Figure 3 shows adolescent's relationship (marital) status in the two counties. Overall, over half of respondents in both counties mentioned that they are either married or currently have a boyfriend. The proportion of adolescents married or living together ranged from 26% in Narok to 17.5% in Homa Bay County. Nearly two in five adolescents (40.6%) from Homa Bay and one-third (32%) from Narok reported being in a relationship with a boyfriend. However, about one-third of respondents in both counties reported never being in a relationship.

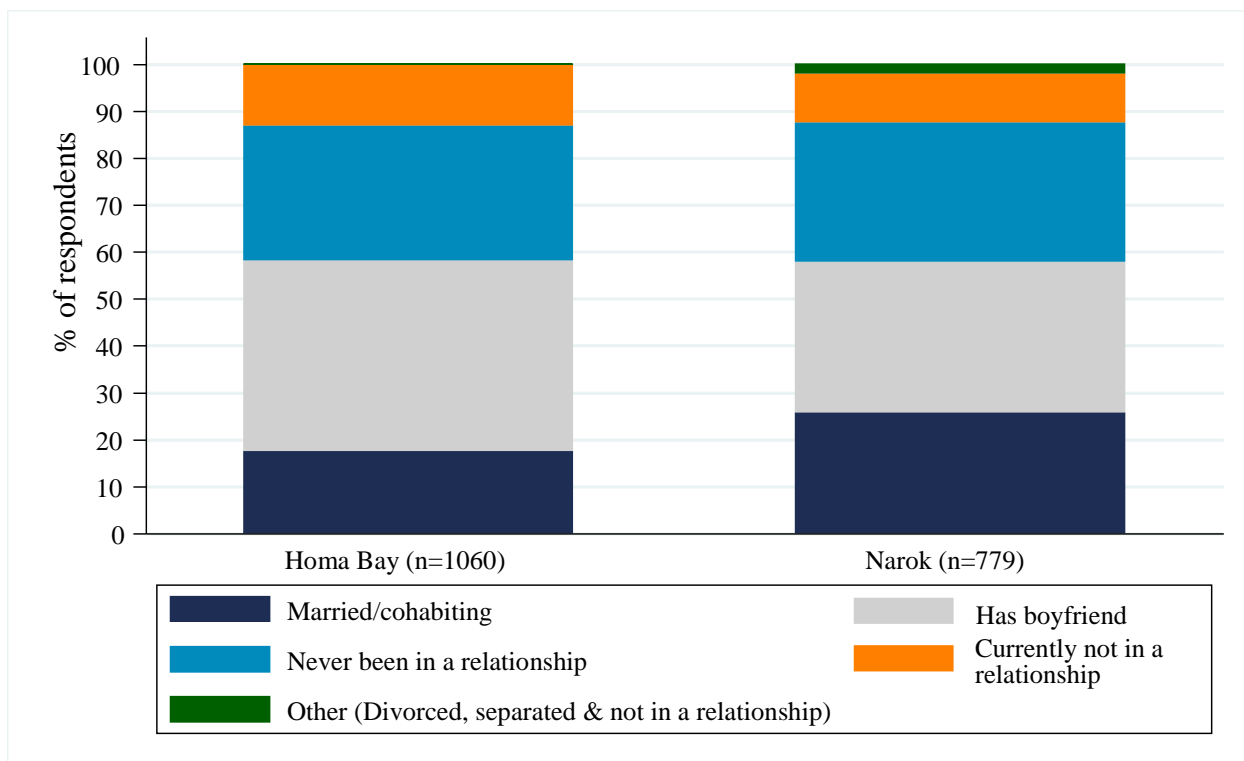


Figure 3: Respondent's current relationship status by county

### 3.2 Access to information and services

Adolescents and young people will be able to exercise freedom of choice regarding sexual matters, marriage and reproduction if they get access to accurate sexual health information and comprehensive sexual health services. Of the 1,061 respondents in Homa Bay, 58%, 62% and 76% had received information on SRH, pregnancy prevention and STIs respectively in the six months preceding the survey. Similarly, of the 779 respondents in Narok, 45%, 55% and 63% had received information on SRH, pregnancy prevention and STIs respectively. The respondents were also asked about their main sources of information. Figure 4 shows respondents' main sources of information for SRH, pregnancy and STIs (including HIV) by county. For both counties, the main source of information on any of the three indicators was teachers (including school-based mentors), closely followed by friends/relatives. It is important to note that less than 4% of respondents mentioned parents as the main source of information on SRH and STIs, while none of the respondents mentioned parents as a source of information about pregnancy prevention (Fig 4).



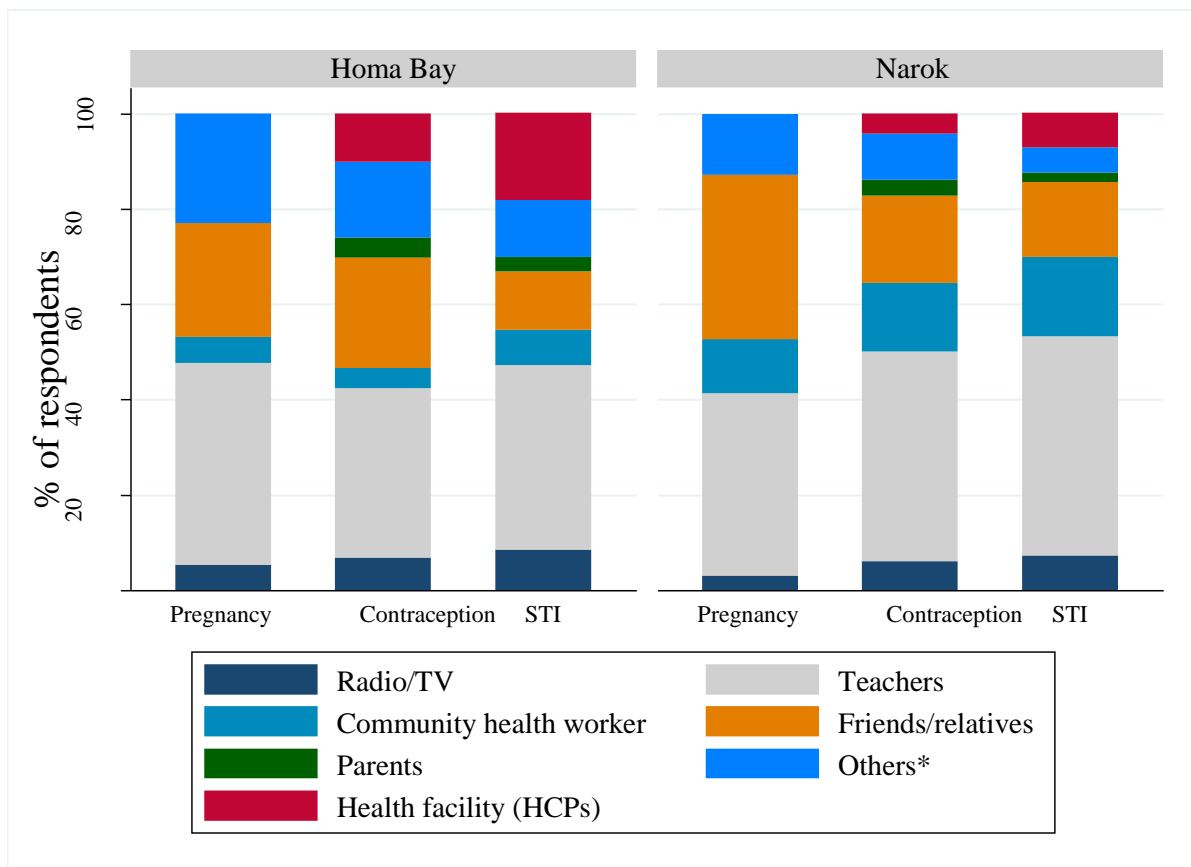


Figure 4: Main source of respondents' information about SRH by county

Data from qualitative study also indicated that adolescent girls have diverse sources of information on sexual and reproductive health. Friends, peer educators, the media, CHVs, school teachers and churches are among the main sources. In schools, adolescent girls receive SRH information mostly when being taught in class as a topic in a particular subject.

*“At school, when you are in class six you are taught about reproductive system and when you are in class eight you are taught how one can give birth. But on protection you are only taught in class seven on HIV and AIDS.”*

*Adolescent girls IDI, (15 year old, rural, Homa Bay, class 8 pupil, single)*

Parents are also cited as sources of information, but this does not occur more often because of the discomfort for both parents and adolescents to talk about these issues:

*“We have a CHV here, she does come and counsel our young girls – like the new mothers. When they come, as a parent, I have to respond and give her the chance to talk to the child, but if she also wants to consult me, I may also wait and listen, why – because as a CHV, there are things they know about counseling which they may know more than I do as a parent.”*

*Maybe the child is free with her and can talk to her better than she can talk to me. So I feel better if the child can tell her what she couldn't tell me and she will call and tell me that I talked to the child."*

Parent FGD, rural Homa Bay

Although only a small proportion of adolescents in both counties mentioned media as their source of SRH information, our survey indicates that adolescents have a relatively good access to media, particularly television and radio in the two counties. Figure 5 shows that the majority of adolescents in both counties have access to radio, television, newspapers and magazines such as Shujaaz. Ownership of mobile phones is relatively lower with 31% of respondents in Homa Bay and 41.5% in Narok reporting ownership of a mobile phone. Similarly, the proportion of adolescents who reported owning a social media account (Facebook, WhatsApp or Instagram) was very low in both counties (13.1% and 17.2% in Homa Bay and Narok respectively).

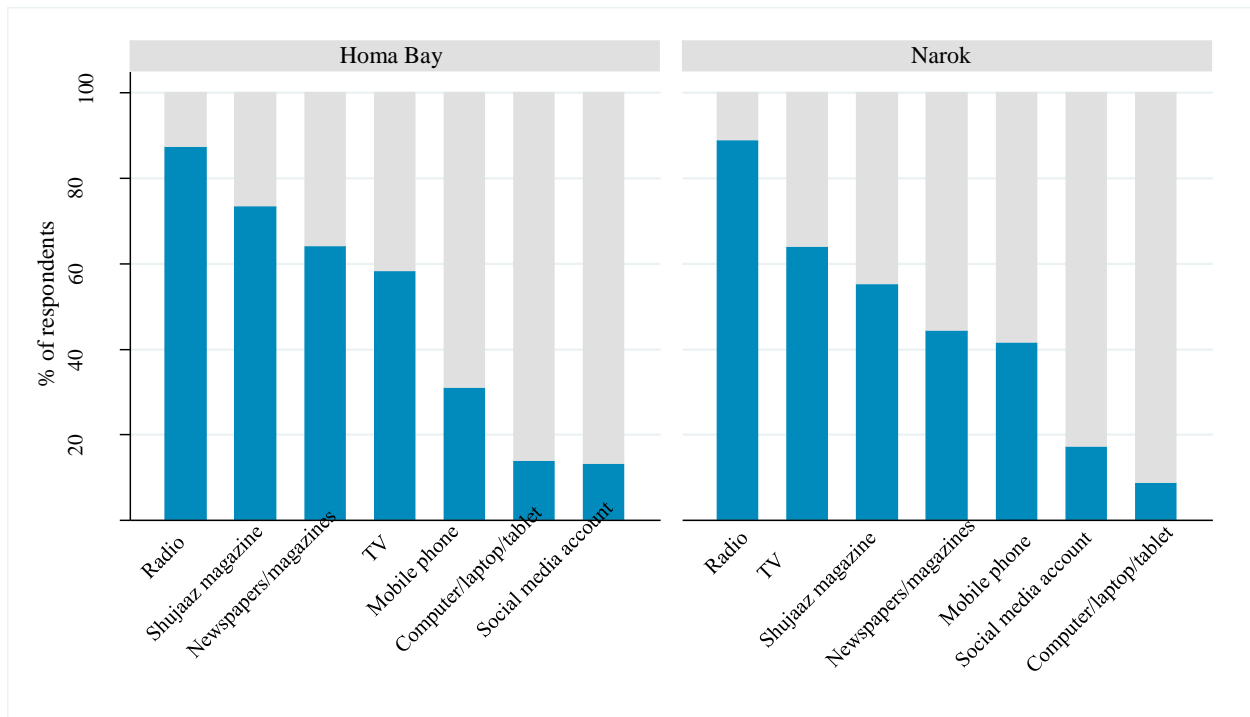


Figure 5: Adolescent girls' access to media

In the qualitative study parents pointed out the negative influences of media on adolescents' behavior. Some described them as “dressing scantily” and being disrespectful to parents, referring to them as “kichwa ngumu” (hard-headed), unable to listen to parents, and only paying attention to friends or getting advice from [social] media, which according to parents is a negative influence for adolescent girls.

*“The adverts and programs that are there make it worse and the closest friend to a child is the television because when you go to work and leave the child in the house she/he will spend the whole day watching and listening to music. And the music is not like that of our time because nowadays they will even mention sex.”*

Parents FGDs, urban Homa Bay

### 3.3 Knowledge of contraception and fertile period

Overall, about 98% of respondents in each of the two counties had knowledge of at least one method of modern contraceptives. Specifically, male condoms (97%), injectables (88.7%) and implants (87.3%) were the modern contraception methods most commonly known by the respondents in Homa Bay. Similarly in Narok, a higher proportion of respondents mentioned knowledge of the three methods (Figure 6). Notable also from the figure is that most of the respondents in both counties expressed knowledge of modern contraceptive methods after probing. IUD and emergency contraception were the least known methods even after probing. There are generally higher levels of contraceptive knowledge among adolescents aged 18-19 years, those living in urban areas, and those with secondary or higher level of education in both counties (see annex).

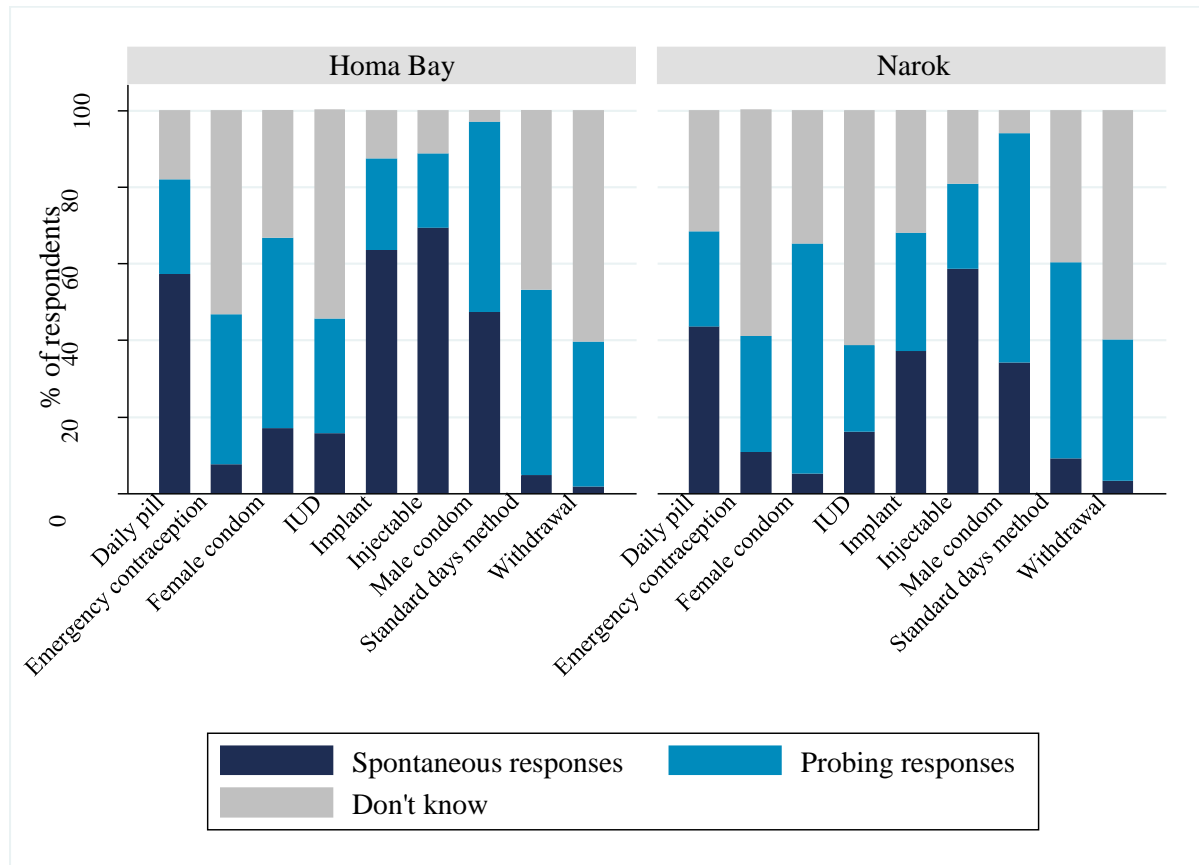


Figure 6: Respondents' knowledge of contraceptives by county

Furthermore, 83.0% and 75.6% of respondents from Homa Bay and Narok said they know at least one place from where to obtain contraceptives. Figure 7 shows that about 70% of the respondents in both counties mentioned a government hospital, as the top main source of contraceptives, while private hospitals (29%) and private clinics (41.5%) were also prominent sources in Homa Bay.

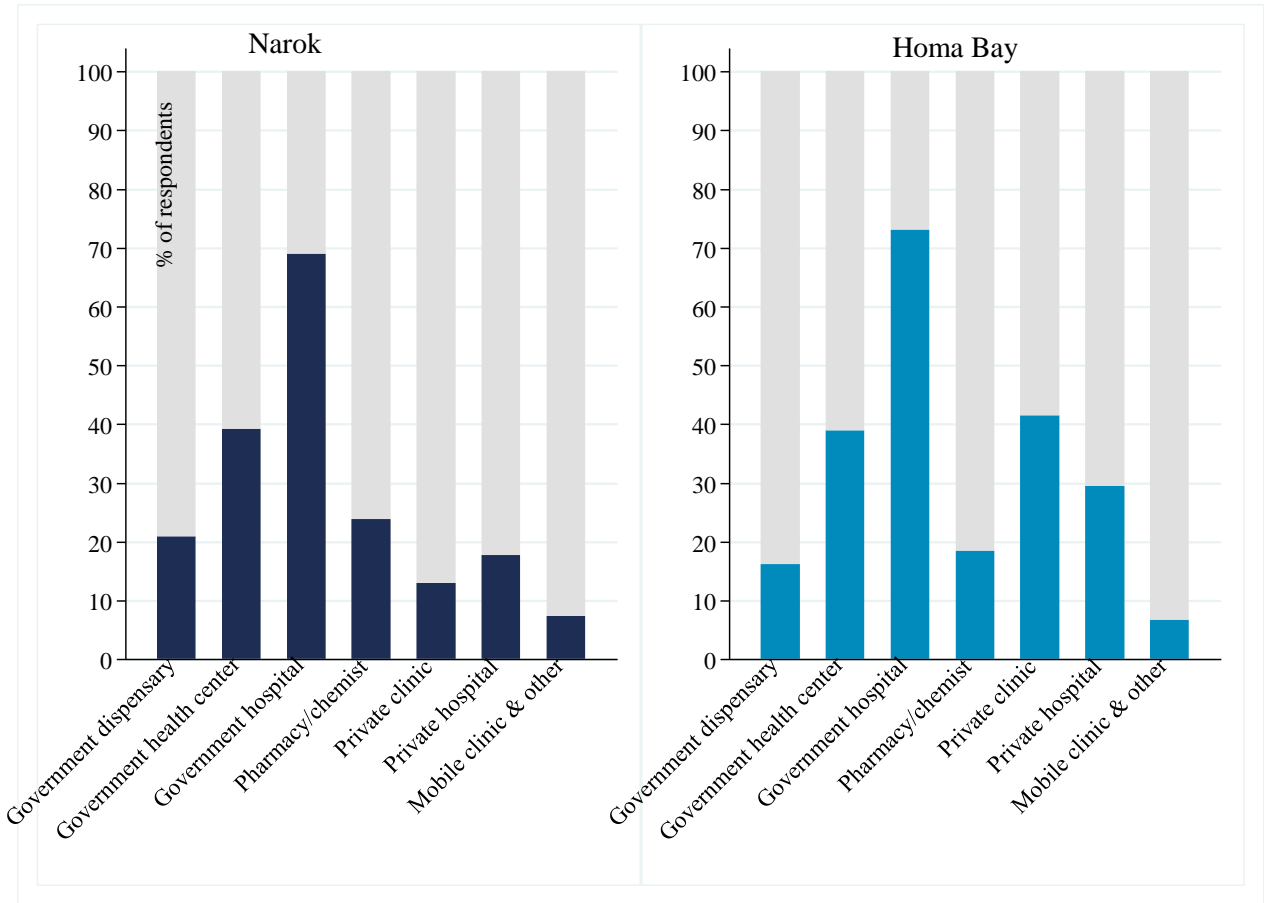


Figure 7: Adolescents' knowledge of source of contraception by county

Respondents were also asked to list ways in which people can avoid sexually transmitted infections (STIs). Use of condoms (Homa Bay 77.2%, Narok 57.4%) and abstinence (Homa Bay 65.1%, Narok 51.6%) were the two main ways of preventing STIs mentioned by respondents (Figure 8).

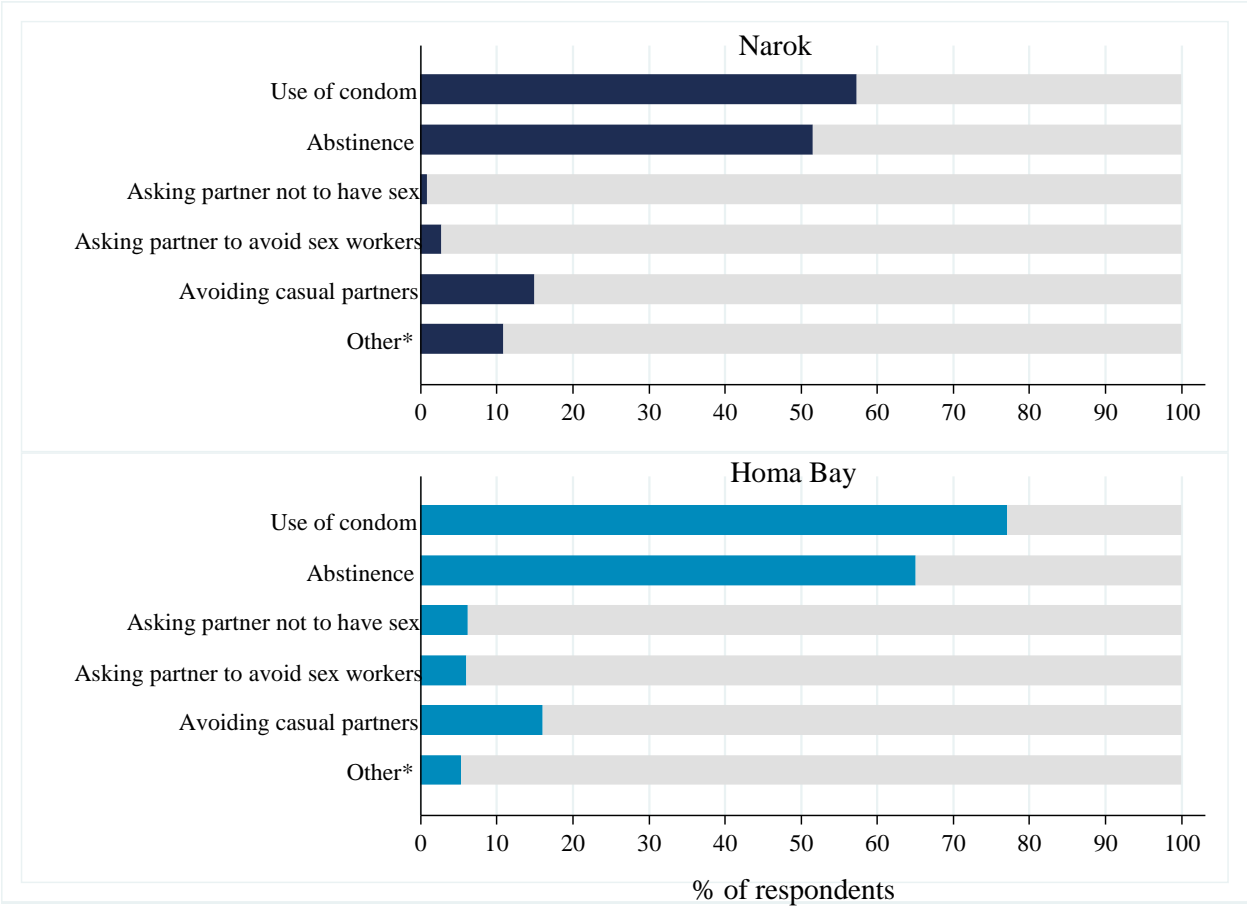


Figure 8: Adolescents' responses on ways of preventing STI transmission by county

Furthermore, 86.7% and 91.6% of respondents in Homa Bay and Narok respectively said that they were aware of certain days between menstrual periods when a woman is more likely to become pregnant if she had sexual relations. However, only 15.5% and 13.0% of these in Homa Bay and Narok were respectively aware of the correct period – within the two weeks after a menstrual period (Figure 9).

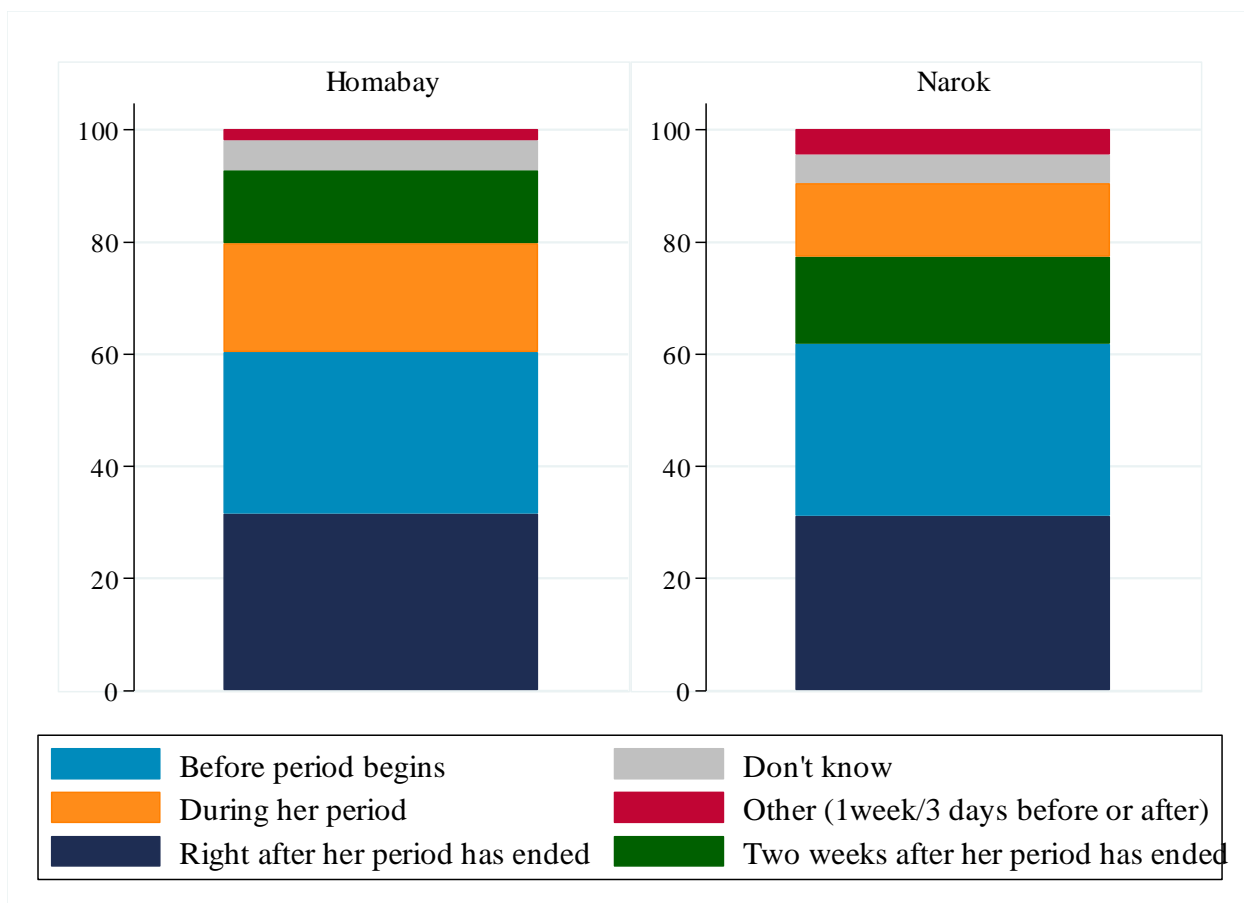


Figure 9: Knowledge of fertile period by county

### 3.4 Perceptions regarding adolescents' sexuality and reproductive health

Qualitative data revealed the community's perceptions on adolescents' sexuality and reproductive health, specifically how the parents, community health volunteers (CHVs) and adolescents understand issues of adolescent sexuality, use of contraception and abortion among others.

**Sex and relationships:** IDIs with adolescents and FGDs with parents and CHVs revealed that premarital sex is perceived as “dangerous” “bad” “wrong”, and bringing disastrous repercussions such as diseases (STIs), HIV, pregnancy and dropping out of school, and getting married as a second wife, among other negative consequences:

*“Parents tell you that such things are bad when you are in school, you can be pregnant, you can be sick and you can have psychological problems which can lead to your failure in school.”*

IDI, Adolescent girls (15 year old, student, single, no child, rural Homa Bay)

*“We tell them, sex is not for children. We tell them that there is a time for it, and this is not the time to have sex.”*

Parents FGD, rural Narok

Moreover, romantic relationships are mostly associated with sex, and adolescent girls are thus discouraged from engaging in romantic relationships.

*“Parents just tell you that romantic relationships are bad because when you have friends, they can do bad things to you that will lead you to wrong places – they can trick you.”*

IDI, Adolescent girls (15 year old, class 8 pupil, single, no child, rural Homa Bay)

As a result of the perception about sex and romantic relationships as dangerous, discussions between parents and adolescent girls tend to have a strong focus on abstinence – until marriage or after completion of school – as the most effective way to escape these perceived dangers. This discourse prevails despite a general awareness that most school-going adolescents are sexually active and the perception by both CHVs and parents that adolescent girls are more sexually active than ever.

A few CHVs however expressed divergent views. These CHVs indicated the need to acknowledge and accept attraction and love are a natural part of life for young people. They considered it important for parents to realize that denying young people’s sexuality only comes back to bite parents as they have to deal with early and unintended pregnancies. These CHVs indicated the need to be realistic, move with the times and the need for a discursive shift.

*“Instead of solely focusing on abstinence children can learn different ways of expressing love, they can be taught to delay sex.”*

CHVs FGD, urban Narok

**Contraception:** In the adolescent survey, over 56% of respondents from both counties reported that they believe contraception causes infertility. Qualitative data highlighted various perceptions regarding contraceptives and their utilization. Adolescents, parents and CHVs in both Narok and Homa Bay consider contraceptive use as suitable for married women only. This is largely due to widely held perceptions that using contraceptive methods before child bearing can lead to infertility, diseases or fetal malformation.

*“No - parents do not want [to discuss] issues of family planning because right now I am still a student. Those are things for married people.”* (

IDI, Adolescent girls (18 year old, student, single, no child rural Homa Bay)

The perceived negative effects of contraception methods are so strongly held, that it is preferable for an adolescent to give birth, than suffer the perceived consequences of using contraceptives.

*“It is even better for your daughter to give birth and take care of her baby rather using family planning methods.”*

CHVs FGD, urban Narok

Also, according to parents and CHVs in both Narok and Homa Bay, teaching adolescents to use contraceptives is considered as encouraging adolescents to have sex.

*“When they start using contraception they get out of control” “Atafanya usherati” – “she will become promiscuous.”*

Parents FGD, Rural Narok

*“If you tell the girl the ways of family planning, you will be letting her to associate with boys freely. It means that have told her the ways of not getting pregnant. But you have not prevented her from being infected. So that is not best way because it will not prevent infection, the best way is to teach them to be God fearing so that when they grow up they will be free to choose.”*

Parents FGD, Urban Narok

Moreover, some CHVs consider providing information on contraceptives to be inappropriate for adolescents, with the idea that contraceptives are only for married women.

*“About family planning, those adolescents of that age between 15 years to 19 years, we never talk to them to use family planning methods. We only teach women about family planning because when we tell adolescent about family planning methods it will be like we are encouraging them to engage in sex because they know they will not get pregnant. So it will be like we are giving them the freedom of engaging in sex.”*

CHVs FGD, rural Narok

It is however important to note that conversations about contraceptive use between parents (or other adults) and adolescents often occur after the first pregnancy, as parents realize the need to prevent another pregnancy from occurring.

*“After I got pregnant, I started getting a lot of advice and information [on contraceptives]. I wish I was given this information earlier.”*

IDI, Adolescent girls (18 year old, out of school due to pregnancy, single, urban Narok)

CHVs also indicated making exceptions for adolescent girls who are already mothers and still in school to prevent them from getting pregnant again.

*“For those who have already given birth and they are in school we tell them to use protection, family planning or condoms.”*

CHVs FGD, rural Narok

According to some CHVs, there has been a realization that adolescents are sexually active. As such, CHVs find it necessary to teach about condom use in schools and churches and distribute them in the community.



*“For us as CHVs as we walk from village to village doing our work we carry condoms because these adolescents are sexually active, like when I was in my village a boy came and request me to give him a box of condoms, so we give them if they cannot control themselves from doing sex but we do not encourage sex.”*

CHVs FGD, rural Narok

However, even though CHVs distribute condoms, they struggle not to be perceived as encouraging sexual activity among adolescents and in some cases provide inaccurate information as they work, so as to deter young people from engaging in sex.

*“...but we do not encourage sex. You know sometimes they feel that they want to engage in sex, so we give them condoms which are not 100 percent sure (effective). So if an adolescent comes and tells you that I don't want to do sex without a condom, we give them.”*

CHVs FGD, rural Narok

Moreover, condoms are mainly distributed to older adolescents, above adult age (18 years and above) and often to male adolescents. Adolescent girls, according to CHVs, are not willing to openly demand for condoms. This demonstrates how socio-cultural perceptions of girls' expressions of sexuality limit girls from taking charge of their own protection by seeking condoms.

As a result of the perceptions surrounding contraceptive use, adolescents do not get accurate information on contraceptives, but rather, information that is based on “myths and misconceptions”. These misconceptions pose challenges for girls who are deciding on contraceptive methods (whether or not to use them and which method to use) as indicated by an adolescent girl during a consultative forum in Homa Bay County.

*“It may be difficult for some girls to go for family planning because of myths and misconceptions that we hear – some say that you should go for family planning after doing abortion, and after you give birth – that is when you can go for family planning. But if you have never given birth or had any abortion, it can cause you problems when it comes to getting married.”*

Adolescents Consultative Forum, Homa Bay

**Marriage:** Qualitative data from the FGDs and IDIs indicates that early marriage is discouraged for adolescents across all communities these days. Early/adolescent marriage is often unaccepted and viewed as a source of problems so adolescent girls are encouraged to wait until they have completed school or have their own job:

*“She [mother] told me that I should not get married early because if I get married and I have not gone to school, I will face a lot of problems.”*

IDI, Adolescent girls (17 year old, dropped out of primary school due to pregnancy, single, with one child, rural Narok)

Despite these views, a number of adolescent girls were found to have married early, either due to pregnancy or dropping out of school for lack of school fees. A conversation with a 17 year old adolescent from rural Narok, who dropped out of school due to pregnancy shows:

*“Here it doesn’t matter because the problem here is that for example like me, you [adolescent girl] have finished class eight and you don’t have money to go to high school so you end up staying at home. Your parents will give you away and there is nothing you can do because you have no option.”*

IDI, Adolescent girls (17 year old, dropped out of primary school due to pregnancy, single, has a child, rural Narok)

This indicates a contradiction between the aspirations that parents have for their daughters as well as those of adolescent girls, and the reality of getting pregnant and getting married. Moreover, early marriage is still practiced in some communities, particularly in rural Narok, especially in areas where it is common for girls not to attend school as seen in the case of one adolescent girl who had never been to school.

*“During my time, a girl was not the one to search for a husband for herself, it is not like you get into an affair with someone and ends up in marriage, a man just come and you are married off to him whether you like it or not...from the area I was born, girls who had gone to school were the ones who selected their husbands by themselves but for us who did not go to school then the parents did it for us.”*

IDI, Adolescent girls (19 year old, never been to school, married, house wife, rural Narok)

### **3.4 Adolescents’ decision making autonomy and self-esteem**

Adolescents’ decision making autonomy in relation to key sexual and reproductive health issues of relationships, sex and contraceptive use was assessed through the qualitative and quantitative studies at baseline. In the adolescent survey, respondents were read a series of statements about self-esteem, social networks, decision making and voice and asked whether they agreed or disagreed with statements measuring each of these constructs. This helped us assess their own self-worth and assertiveness based on their own personal characteristics and ability to act decisively. Adolescents’ decision making in relation to key SRH issues were assessed by asking respondents how confident they are in doing certain things that require their decision. These decisions include their confidence negotiating condom use with their boyfriends and or partners, confidence talking about contraception with their boyfriend/husband, confidence asking health care providers questions about contraceptives and STIs/HIV, confidence discussing pregnancy related problems with a health provider and confidence visiting a clinic that provides SRH services. Responses were categorized into four categories (definitely could, probably could, probably could not and definitely could not) and we considered those who reported they definitely could do those things as having good levels of confidence.

Figure 10 shows that with the exception of a few areas, the majority of the adolescents reported confidence in being able to make those decisions and actions. About 50% or more of respondents in

Homa Bay expressed confidence in asking for condom use with their boyfriends, talking about contraceptive methods with their boyfriend or husband and asking a health provider questions about contraceptive methods. In comparison, 30-50% of respondents in Narok reported confidence talking about contraceptive methods with their boyfriend, confidence asking a health provider questions about contraceptive methods or confidence discussing with health providers issues about STIs/HIV and pregnancy related issues. Figure 10 below presents adolescents' level of confidence on certain SRH issues by county.

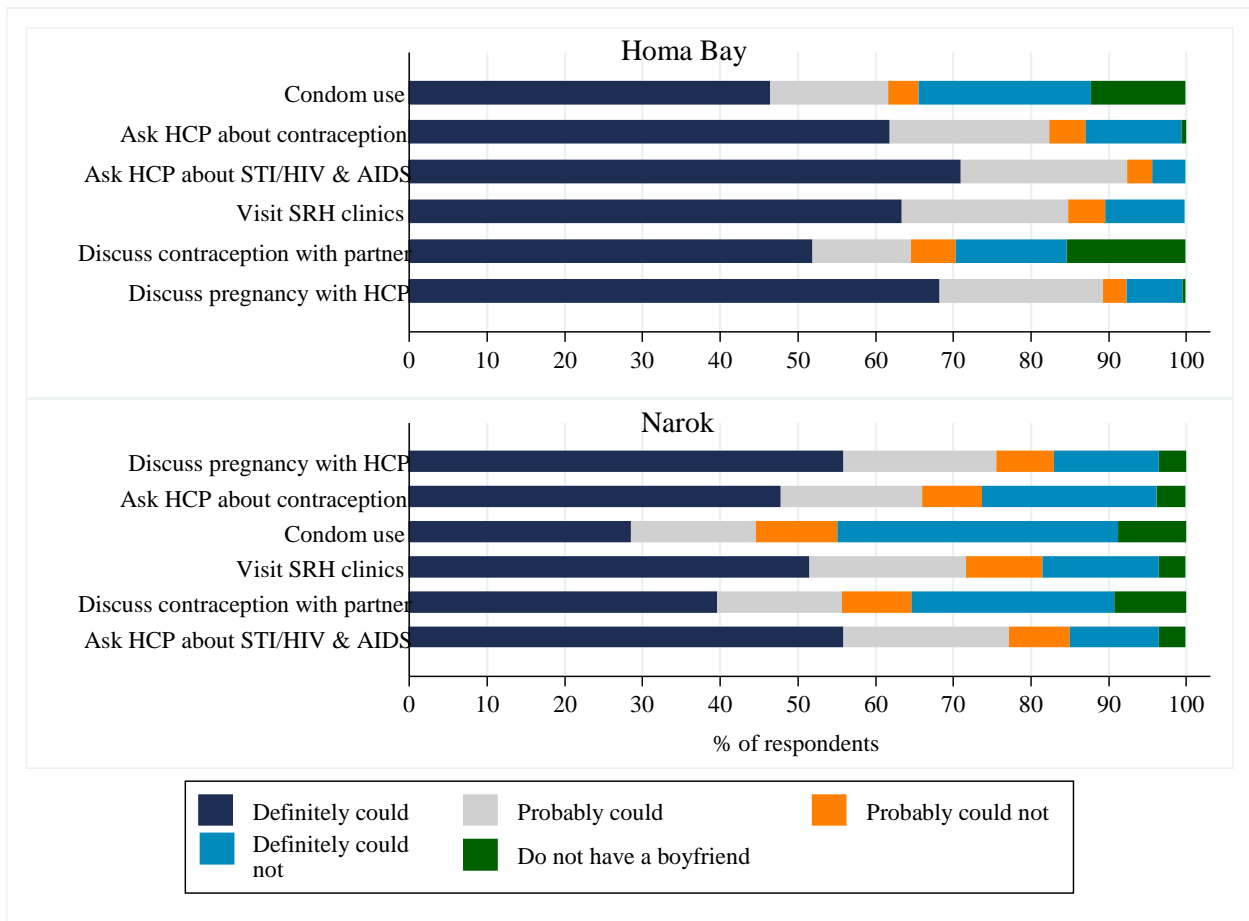


Figure 10: Adolescents' level of confidence on certain SRH issues by County

Qualitative data also highlighted adolescents' decision making experience on matters of relationships, sex, pregnancy and child bearing. Respondents reported different scenarios of decision making related to relationships and sex. Some expressed confidence in being able to reject sexual advances even within a relationship (with boyfriends and partners) while others described how they engaged in a relationship or sex without making a proper decision. A 15 year old adolescent from Homa Bay, still in school, said that she decided to abstain until she completes school and becomes financially independent despite sexual demands from boyfriends.

*"I need to abstain, I abstain currently and I will get into a relationship after I finish education and have something in my hands so that even if I have a problem I can sort it myself."*

It is observed from the in-depth interviews that some unmarried adolescents can assert their right to decline sexual demands from boyfriends and/or choose to use contraception (sex with condom or not). A 15 year old adolescent from rural Homa Bay stated:

*“I will use condom; we were told at glow camp [youth forum] that if you have a boyfriend and they force you into sex but you don’t want or you think that you can do it, you can use protective things like condom.”*

But for some older and married adolescents, the decision to abstain or to use contraception is not easy. They feel obliged to give in to sexual demands from their partners because of social and gender-based norms. Married adolescents interviewed in rural and urban Narok consider sex demands from husband as an obligation to fulfill. A conversation with this 19 year old married adolescent from rural Narok demonstrates this reality.

*Interviewer: What can you do if he wants to do it?*

*Respondent: I will just accept.*

*Interviewer: Why will you accept?*

*Respondent: Because he was away for months at work and when he comes back he wants it so you cannot deny him.*

*Respondent: I am not able to refuse*

*Interviewer: Why are you not able to say no?*

*Respondent: (laughing) when I refuse and the man is asking for it then that is introducing conflicts*

Despite knowledge of contraception being widespread, not all sexually active adolescents are able to use contraceptives to prevent unintended pregnancy. Narratives indicate that adolescents use condoms for protection against pregnancy and also HIV and STIs. Condoms are a relatively preferred contraception method among adolescents in the two counties compared to other methods. A 17 year old respondent married, urban Narok said that she will seek contraception only if her husband refuses to use condoms:

*“If he doesn’t want to use it [condom] all the time, I will go for family planning.”*

Other respondents clearly indicated that condoms should be used for preventing STIs and HIV unless they both get tested for HIV.

*“If he doesn’t want to use condom, I will tell him that we should first go and get tested.”*

IDI, Adolescent girls (16 years, single with no child, Urban Narok)

The survey also assessed adolescents’ self-esteem which indicates their beliefs about their abilities to produce designated levels of performance. Respondents were asked to report on a series of questions that aimed to assess their self-esteem. The majority of respondents in both counties agreed with the statements on self-esteem including, being happy with who they are and feeling that they have much

to be proud of (Table 3). However, in aggregate, a relatively lower proportion of adolescents (8.3% in Narok; 5.6% in Homa Bay) in both counties had higher self-esteem, defined as affirmative responses to all the ten questions about self-esteem. Majority of the respondents from both counties were categorized in the moderate self-esteem tertile (result not shown).

Table 3: Adolescents' self-esteem and decision-making, by county (% agreeing)

	<b>Homa Bay</b>	<b>Narok</b>
<b>Personal feelings and self-esteem</b>	<b>N=1061</b>	<b>N=779</b>
You feel happy to be who you are	95.7	94.2
You wish you had more confidence	68.6	63.3
You feel you have much to be proud of	69.6	80.0
Your future is determined by luck and not by you	40.0	42.0
You have good ideas/opinions others should hear	93.5	82.0
You feel you can talk to someone and they will listen	92.0	79.3
It is difficult to speak up and defend yourself	36.6	38.4
You know how to achieve your future goals	92.2	82.5
You know what you want to be in the future	92.8	89.7
<b>Agree with the following statements on voice</b>		
Your parents/boyfriend ask your opinion on things	84.9	84.0
Your friends ask your advice when they have a problem	96.4	91.8
You can speak up when you see someone else being hurt.	92.8	84.3
I can ask adults for help when I need it	96.0	95.0

- Percentages not calculated for frequencies less than 10.

In the survey, respondents were asked few questions regarding the opportunity to express their views (voice) and how much their views are listened to. Accordingly, the majority of respondents agreed with the statement that their parents/boyfriend/husband ask for their opinion on things and their friends ask for their advice when they have a problem as an expression of voice (Table 3). Besides decisions about sex and contraceptive use, adolescents' decision making autonomy was assessed by asking respondents about who makes decisions on how to spend money, whether they work for pay or not, whether or not to go to school, when to get married and who to have as friends. Figure 11 shows that less than half of respondents in the two counties make decisions on whether to work for pay or not and whether to go to school or not. A relatively higher proportion of respondents in both counties reported that they themselves make decisions about when to get married and who to have as friends. Overall, fewer adolescents participate in decision making on all the items included in the

survey, with 27.5 % of respondents from Narok and 22.3% from Homa Bay reporting their participation in all decisions (results not shown).

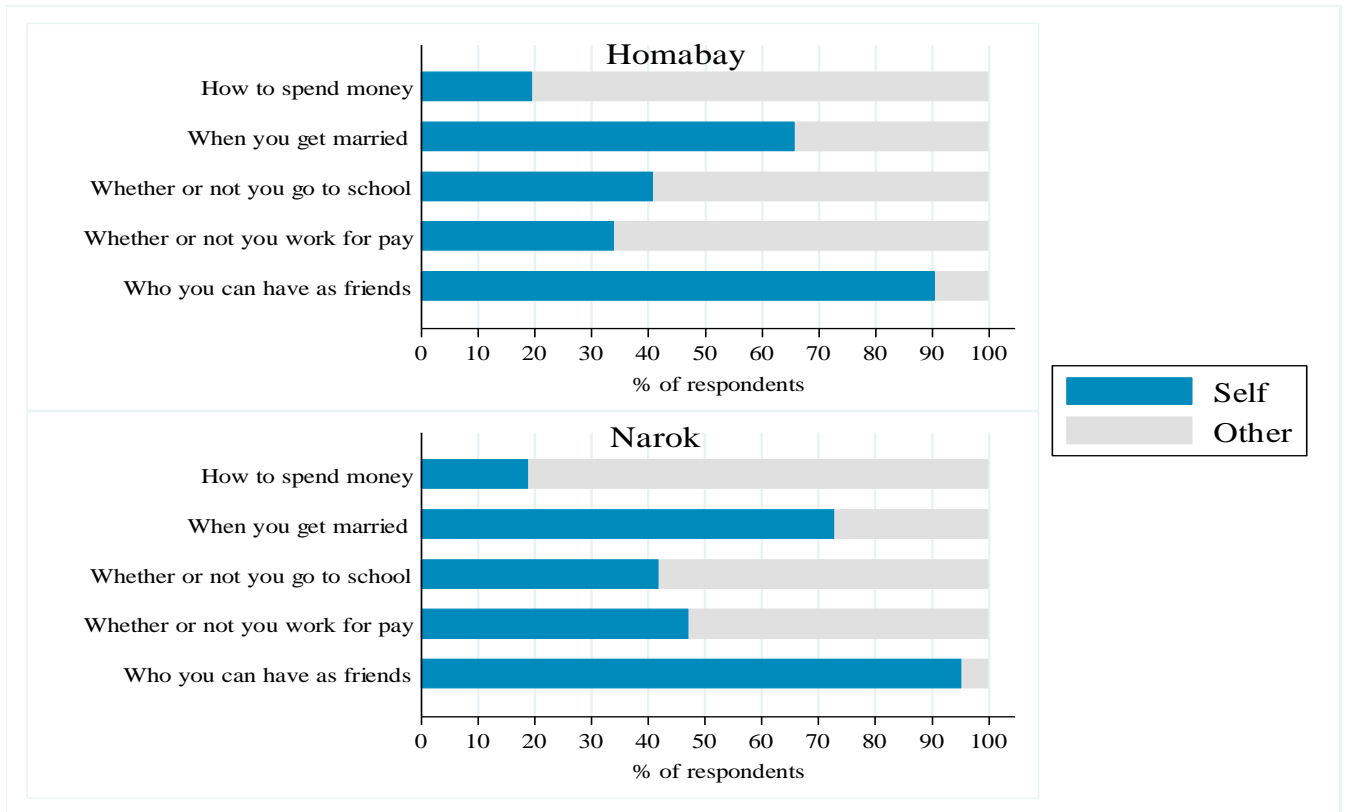


Figure 11: Respondents’ decision making on selected aspects

Regarding social networks, the quantitative study assessed the extent to which adolescents interact with other individuals, groups or organizations in their communities. Overall, adolescent girls in the two counties reported lower social participation rates except in situations of going to church or mosque and participating in sports or games with their female friends (Figure 12). Only a small proportion of adolescent girls reported participating in community meetings, savings groups, going to youth centers and participating in mixed gender sports or clubs (Figure 12).

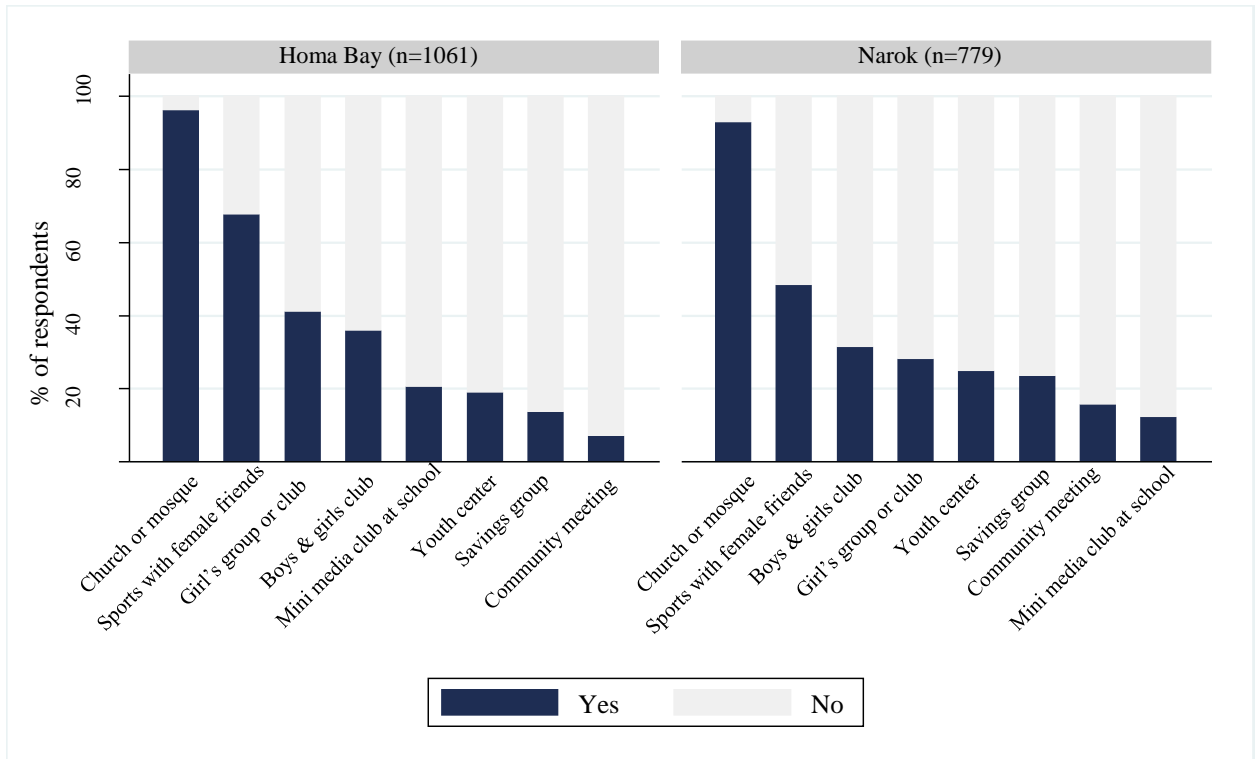


Figure 12: Adolescent’s social networks by County

### 3.5 Sexual behavior and utilization of SRH services

#### 3.5.1 Sexual activity and unwanted pregnancies

Early sexual debut is common in both Homa Bay and Narok counties. Sixty two percent of adolescent girls interviewed in Homa Bay and 58% in Narok had engaged in sex, with 40% of girls in Homa Bay and 29% of girls in Narok having done so by age 14 (Figure 13). The mean age at the time of first sexual initiation is 14.9 years in Homa Bay and 15.3 years in Narok. About 50% of girls in both counties (50.1% in Homa Bay; 49.4% in Narok) were sexually active in the 12 months preceding the survey. Having multiple sexual partnerships is also common in both Narok and Homa Bay counties: 46% of girls who ever had sex in Homa Bay and 52% in Narok have had two or more sexual partners in their lifetime.

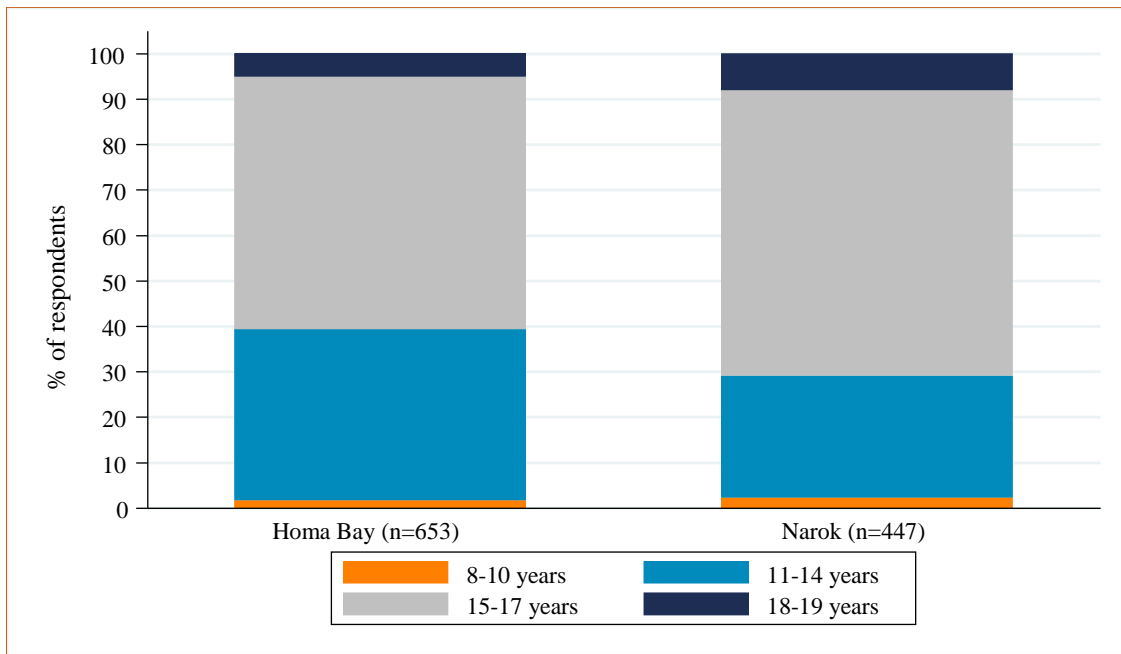


Figure 13: Percentage of adolescent girls initiating sex, by age group and by county

Pregnancy rates are relatively high in both Narok and Homa Bay counties in comparison to the national level: 34% and 32% of respondents in the respective counties have ever been pregnant (Figure 14). These high rates of teenage pregnancies in both counties have been well documented and explained by high levels of teenage marriage. About half of women (25-49 years old) are married by age 19 in both counties<sup>1</sup>. Of concern, is that 69% of girls in Narok and 83% of girls in Homa Bay who had ever been pregnant did not want the pregnancy at the time (mistimed) or at all (unwanted) (Figure 15).

<sup>1</sup> [https://www.afidep.org/download/Fact-sheet\\_Narok-County2.pdf](https://www.afidep.org/download/Fact-sheet_Narok-County2.pdf),  
[https://www.afidep.org/download/Afidep\\_ASRH-Homa Bay-County-Final.pdf](https://www.afidep.org/download/Afidep_ASRH-Homa Bay-County-Final.pdf)



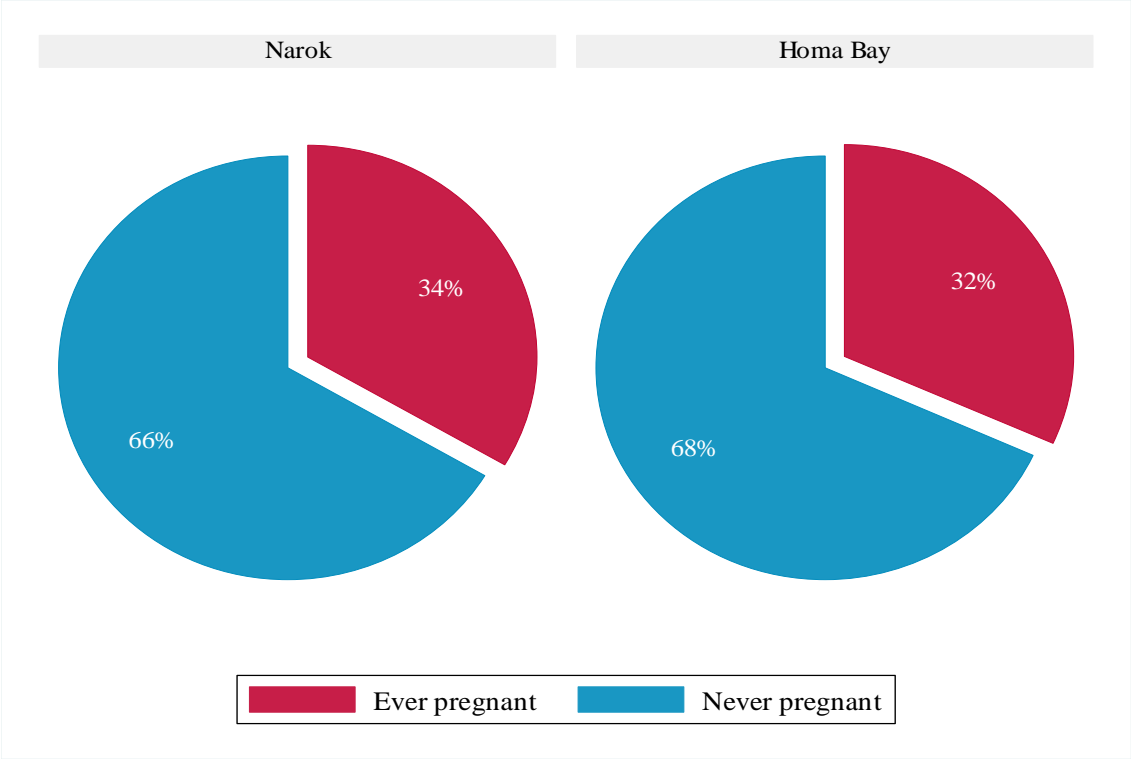


Figure 14: Pregnancy rates among adolescents in Narok and Homa Bay counties

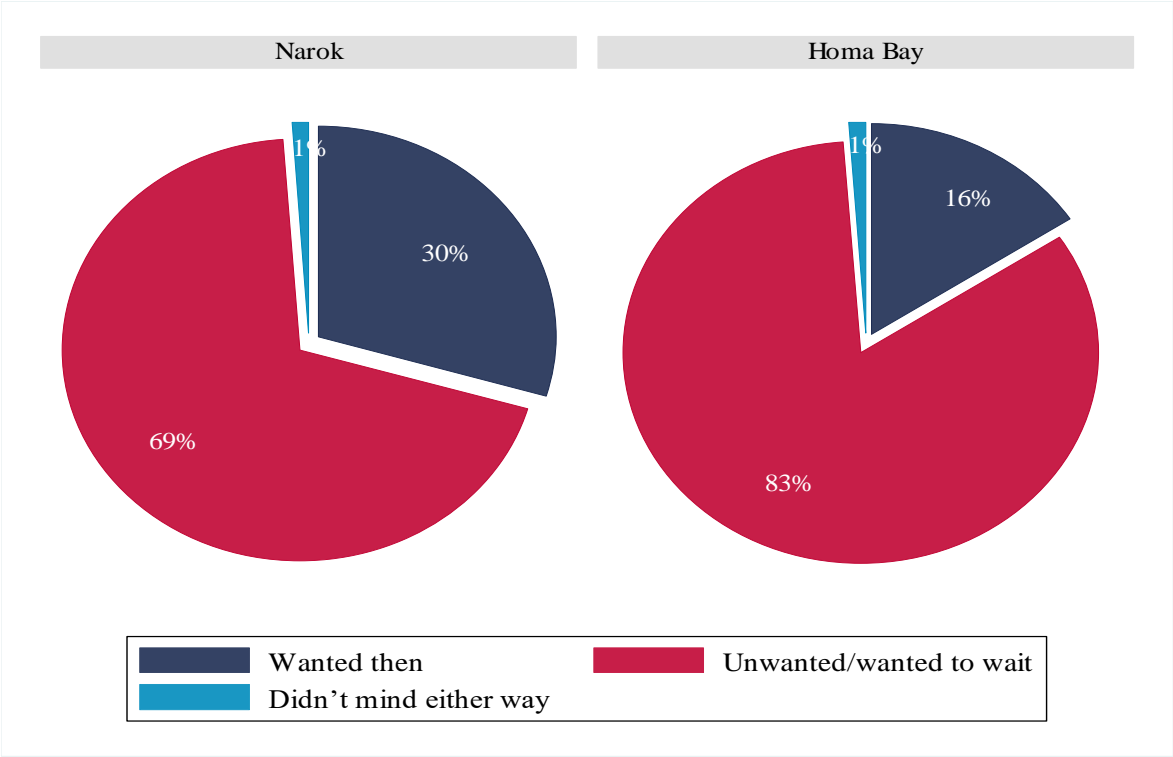


Figure 15: Unintended pregnancy among adolescents who were ever pregnant

In the qualitative interviews, adolescents justified these pregnancies with different reasons. One of the reasons, according to a 19 year old teenage girl from Ololunga in Narok south, are ‘tricks’ used by boys in romantic relationships. According to her, boys play with their emotions which leads to unprotected sex.

*Interviewer: You have told me about pregnancies and such, what causes people to have early pregnancies or unplanned pregnancies?*

*Respondent: Just being tricked.*

*Interviewer: Tell me how.*

*Respondent: You know sometimes boys do challenge us, they tell you they love you but after they impregnate you they avoid you and tell you that they don't know you.*

*Interviewer: Tell me what happened in your case.*

*Respondent: I was just tricked.*

IDI, Adolescents, (Rural Narok, 19 years old, single with a child)

The failure of natural contraceptive methods such as standard days method and the irregularity of the menses was found to be contributing to unplanned pregnancies among adolescents who used these methods:

*“Some people have irregular monthly periods while for others it is regular. Those who have irregular periods may have sex and suddenly they are pregnant without expecting it.”*

IDI adolescent, (Rural Narok, 18, single and currently pregnant)

The lack of information on how to prevent pregnancies (the use of condoms for instance), and also the lack of people to whom to go to for confidential sexuality counselling were also reported as principal causes of unplanned pregnancies. The fear that information about what they consider to be a “shame” (having sex, transactional sex, STIs among others) would deprive young women of services that could help them prevent unplanned pregnancies. Similarly, misconceptions about contraception and barriers to contraceptive access in health facilities appear to be other factors limiting use and access to contraceptive methods.

### 3.5.2 Contraceptive use

Modern contraceptive use is the most effective way to prevent unintended pregnancies among sexually active adolescent girls. Contraceptive use is particularly important in both counties as the percentage of girls who accurately know their fertile period is low (16% in Homa Bay; 13% in Narok). The contraceptive prevalence rate (CPR) – any method – among all girls was 37% in Homa Bay and 21% in Narok. The rate jumps to 60% in Homa Bay and 36% in Narok when considering in the

denominator only girls who have ever had sex (i.e. the population at risk). These levels of CPR are relatively high compared to the average national levels for adolescent girls in Kenya as shown in the 2014 KDHS.

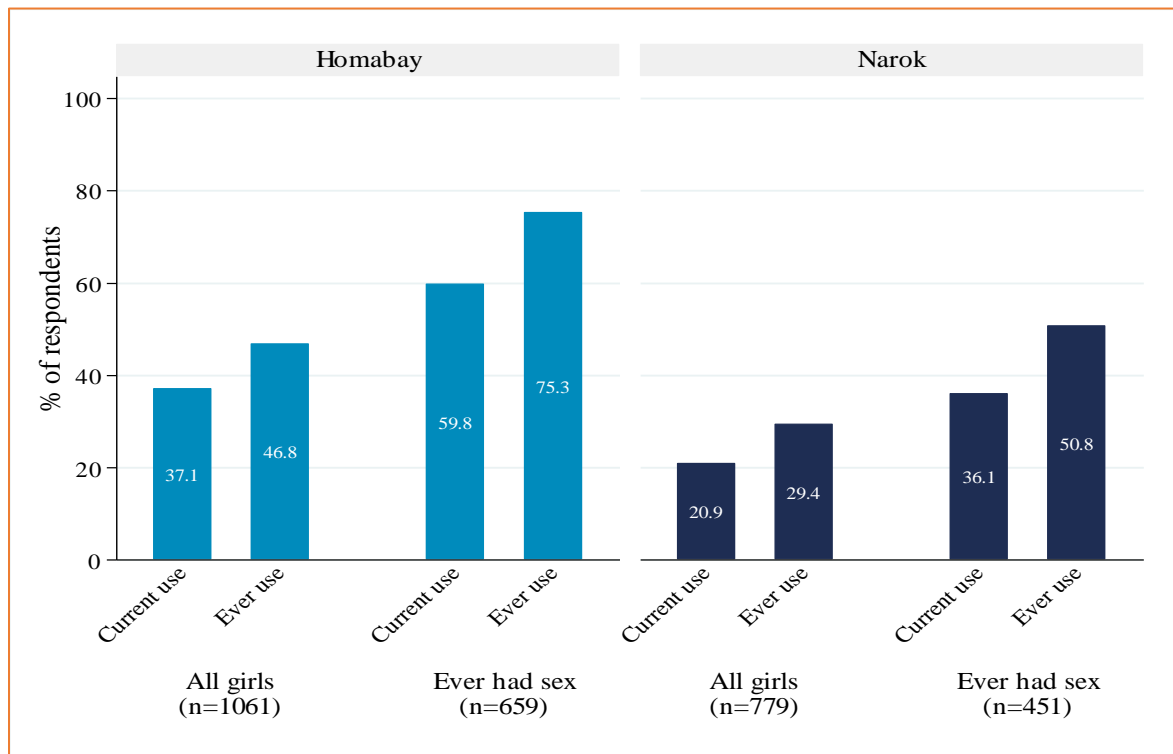


Figure 9: Contraceptive use (any method-ever used and current use), by county

Despite the relatively high CPR in both counties however, the findings show that most girls use condoms (32% in Narok; 61% in Homa Bay). This is not necessarily the most effective method for pregnancy prevention but it offers dual HIV and pregnancy protection. The percentage of girls using condoms was particularly high among younger girls (62% in Narok; 74.2% in Homa Bay). The second and third most common modern contraceptive method among sexually active girls in both counties were injectables (35% in Narok; 14.3% in Homa Bay) and implants (23% in Homa Bay; 22% in Narok). Injectables and implants were mostly used by older girls (18-19 years) and girls living in urban settings in both counties (Figure 17).

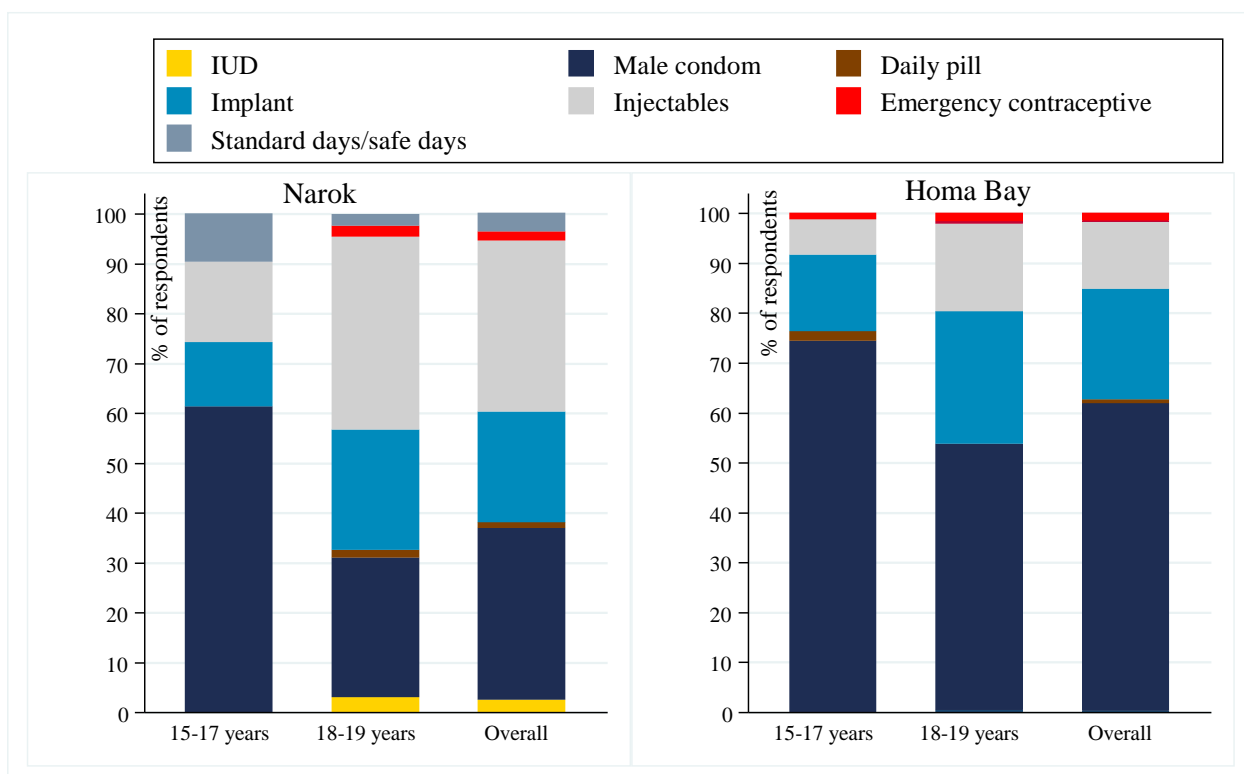


Figure 10: Contraceptive method mix by age and county

The public sector is the major source of contraceptives for adolescents and they rate the quality of services as satisfactory. About 94% of respondents who have visited health facilities for contraceptives said they obtained the method of their choice during their last visit, majority said they were the ones who had the final decision about the method they received. Over 90% of respondents said they would return to the facility and also refer a friend to that facility, indicating a high level of satisfaction with the services received.

Information about the side effects of the method they chose and what they should do when they encounter such problems is important as it assists users to make decisions on which method works best for them and in coping with the side effects. Nearly 56% and 54% of respondents from Homa Bay and Narok respectively said they were informed about other contraceptive methods; 57% and 56% of respondents from Homa Bay and Narok respectively reported that they were informed about side effects of the methods they received; nearly 59% and 55% of users from Homa Bay and Narok reported that they were informed about what to do if they experienced side effects (Table 4).

Table 4: Quality of family planning services among adolescents that visited facilities to seek family planning

Characteristic	Homa Bay N=190	Narok N=114
	n (%)	n (%)
Informed about other methods of contraception	105 (55.3)	57(50.0)
Informed about side effects	111 (58.4)	65 (57.0)
Told what to do if experienced side effects	105(55.3)	62 (54.4)
Obtained the method wanted during last facility visit	176 (93.9)	107 (93.9)
Who made the final decision about the method you got?		
Me alone	101 (53.2)	74 (64.9)
Provider	4 (-)	1 (-)
Partner	14 (7.4)	14 (12.3)
Me and provider	9 (-)	1 (-)
Me and partner	50 (26.3)	21 (18.4)
Other	12 (6.3)	3 (-)
Would return to that facility	178 (93.7)	109 (95.6)
Would refer a friend who is also an adolescent to that facility	181 (95.3)	105 (92.1)

- Percentages not calculated for frequencies less than 10.

However, qualitative data highlighted various perceptions regarding contraceptives and their utilization that could explain high levels of condom use. Modern contraceptive methods such as injectables or hormonal methods in general are seen in both counties as something that leads to infertility if used before child bearing. In the survey with adolescents, 56% of respondents believed that contraceptives can cause infertility. Moreover, these contraceptive methods are considered to be indicated for married woman, not for children/adolescents.

*“She told me they lead to some problems. You may fail to get pregnant and there are also other diseases that they may bring to the body”.*

IDI, Adolescent girls (Homa Bay, 17, in school)

*“I am saying that if you use injections you can get a child without arms, and legs, I heard that in school”*

IDI, Adolescent girls (Urban Narok, 19 years old, student, single, no child)

The perceived negative effects of contraceptive methods also resonate with the CHVs who seemed to focus on condom use during their SRH education with adolescents. Asked why some CHVs focus on condoms during their SRH education for adolescents.

*“You know these children who are 15 years when they use family planning methods it affect them in a negative way like if you have not given birth one may end up getting no child because of family planning methods so we advise them to use condoms”.*

IDI, Adolescent girls (Rural Narok, CHV FGD respondent)

Also, according to the FGD findings with parents and CHV in both Narok and Homa Bay, there is a general perception that teaching adolescents to use contraceptives encourages them to have sex and that contraceptives do not protect one from diseases. This perception plays a role in influencing health care provider’s interactions with adolescent girls accessing contraceptives. Adolescents therefore do not get accurate information on contraceptives, instead they receive “myths and misconceptions”. These misconceptions pose challenges to girls when deciding which contraceptive method to use.

### 3.5.3 Contraceptive use by socio-demographic characteristics

Current contraceptive use by socio-demographic characteristics did not differ much among adolescents in both counties (Table 4). Nevertheless, in Narok County, current contraceptive use among sexually active girls was relatively lower among younger girls (15-17 years), girls living in rural settings, girls with a primary level of education, girls living with their fathers only, and girls who have been separated. In Homa Bay County, relatively lower rates of current contraceptive use were observed among girls with both parents not alive, and girls who were married or cohabiting (Table 5).

Table 5: Contraceptive use by socio-demographic characteristics and county

Characteristic	Current use among ever had sex		Current use among sexually active	
	Narok N=447	Homa Bay N=650	Narok N=385	Homa Bay N=532
	n (%)	n (%)	n (%)	n (%)
<b>Current age in years</b>				
15-17	31 (27.9)	156 (57.8)	29 (33.7)	128 (61.5)
18-19	132 (39.3)	238 (62.6)	121 (40.5)	208 (64.2)
<b>Residence</b>				
Urban	91 (39.4)	160 (57.6)	84 (41.6)	139 (60.4)
Rural	72 (33.3)	234 (62.9)	66 (36.1)	197 (65.2)
<b>Highest level of Education</b>				
Never attended school	12 (40.0)	1 (-)	11 (37.9)	1 (-)
Primary	71 (33.8)	180 (59.6)	76 (42.7)	158 (63.2)
Secondary and above	80 (38.7)	213 (61.9)	63 (35.4)	177 (63.7)
<b>Biological parents alive</b>				
Both parents alive	112 (34.5)	314 (60.6)	101 (36.2)	179 (65.1)
Both parents not alive	13 (52.0)	45 (54.2)	13 (56.5)	38 (52.1)
Father only	3 (-)	22 (62.9)	3 (-)	19 (67.9)
Mother only	35 (42.7)	113 (63.5)	33 (48.5)	100 (64.5)
<b>Religion</b>				
Roman Catholic	34 (37.4)	82 (62.6)	29 (42.0)	68 (63.6)
Protestant/other Christian	125 (35.8)	306 (60.5)	117 (37.9)	263 (63.4)

Islam/Other	4 (-)	6 (-)	4 (-)	5 (-)
<b>Relationship status</b>				
Married or cohabiting	83 (41.3)	107 (58.2)	83 (41.5)	106 (57.9)
Has boyfriend	61 (36.3)	232 (66.9)	53 (38.7)	201 (69.8)
Other*	19 (24.4)	54 (45.8)	12 (31.6)	22 (43.1)

\* Other includes - divorced, separated, widowed, not in a relationship

- Percentages not calculated for frequencies less than 10.

### 3.5.4 Reasons for contraceptive non-use and future use among non-users

The major reason for contraceptive non-use in both counties is puzzling and calls for intensive engagement with adolescents on future planning, importance of contraception methods and the choices available. Nearly 27% of sexually active adolescents in both counties reported not using contraceptives because “they never really thought about it” (Table 5). Another key finding is that 9% of sexually active girls in Homa Bay and 8% on Narok reported not using contraception because they do not think they could get pregnant. There is also a need to work with adolescents to develop their skills in negotiating contraceptive use with their sexual partners. In Homa Bay, 12% of sexually active girls and 10% of those in Narok reported not using contraceptives because “it is too hard to get the partner to use contraception”.

Regarding future use, three quarters of all the sexually active non-users in both counties reported that they intend to use a contraceptive method in the future. Most of the girls who reported on their intentions to use in the future said they intend to use implants (42% in Homa Bay; 37% in Narok), and injectables (35% in Homa Bay; 37% in Narok), which contrasts the findings on preferences for condoms among the girls currently using a method.

Table 6: Reasons for contraceptive non-use and intentions for future use among sexually active adolescents, by county

Reasons for not currently using contraceptive	Homa Bay N=195 n (%)	Narok N=234 n (%)
I am too embarrassed to talk about using contraception	12 (6.2)	11 (4.7)
It is too hard to get my partner to use contraception	24 (12.3)	25 (10.)
Contraception interferes with enjoyment	19 (9.7)	10 (4.3)
I don't know where to get contraception	5 (-)	3 (-)
I don't want to seem too eager for sex	15 (7.7)	14 (6.0)
I don't think I could get pregnant	18 (9.2)	19 (8.1)
I have never really thought about it	53 (27.2)	64 (27.4)
I can't afford it	4 (-)	-
Side effects	18 (1.7)	4 (-)
Infrequent sex	5 (-)	7 (-)
Other (parent or partner doesn't support, currently breastfeeding, doesn't like contraception)	14 (8.0)	10 (5.4)

<b>Intend to use contraceptive in the future among currently not using</b>	198 (74.7)	213 (74.7)
<b>Contraceptive method you intend to use in the future</b>		
IUD	1 (-)	7 (-)
Male condom	16 (10.3)	5 (-)
Female condom	1 (-)	-
Daily pill	10 (6.4)	16 (9.3)
Implant	65 (41.7)	64 (37.2)
Injectables	54 (34.6)	63 (36.6)
Standard says/safe days	-	1 (-)
Withdrawal	1 (-)	1 (-)
Other (remove ovary, abstinence, tubal ligation, herbal, not yet decided)	3 (-)	3 (-)
Don't know	5 (-)	12 (7.0)

- Percentages not calculated for frequencies less than 10

### 3.6 SRH services utilization

#### 3.6.1 Utilization of health facilities for SRH services

The proportion of adolescent girls who have used health facilities for sexual and reproductive health services was relatively low in both Homa Bay and Narok counties (Table 6). About 41% of girls in Homa Bay and only 30% of girls in Narok have visited health facilities for SRH services in the past year. Of interest is that the girls who visited facilities for SRH services in both counties did not do so in typical youth-friendly facilities such as MarieStopes clinics, PSK clinics or FHOK clinics, except for 10% of girls in Homa Bay who visited the AMUA clinics. The majority of girls visited public health hospitals (65% in Homa Bay; 72% in Narok). SRH services of particular interest among the girls interviewed included HIV and STI testing, family planning and antenatal care.

Table 7: SRH services utilization at health facilities, by county

Characteristic	Homa Bay	Narok
	n (%)	n (%)
<b>Visited health facility to receive health services</b>	432 (40.7)	232 (29.8)
<b>Health facilities visited in the past six months?</b>		
Public hospital	281 (65.1)	166 (71.6)
Private hospital	28 (6.5)	15 (6.5)
Public health clinic	25 (5.8)	31 (13.4)
Private clinic	43 (10.0)	16 (6.9)
Marie Stopes Clinic	4 (-)	-
Pharmacy	2 (-)	4 (1.7)
Tunza/PSK clinics	2 (-)	-
Family Health Options Kenya (FHOK)	1 (-)	-
MSK (AMUA)	46 (10.7)	-
<b>Health services sought during the visits</b>		



Contraception	114 (26.4)	67 (28.9)
HIV test	258 (59.7)	68 (29.3)
STI test	31 (7.2)	4 (-)
Pregnancy test	41 (9.5)	41 (17.7)
Antenatal care	110 (25.5)	48 (20.7)
Other reproductive health	13 (3.0)	12 (5.2)
Other	18 (4.2)	5 (-)

- Percentages not calculated for frequencies less than 10.

### 3.6.2 User experience

Poor user experience can work in tandem with limited access to youth-friendly services to justify low rates of utilization of services among adolescent girls. When asked to identify perceived problems in accessing SRH information and services, 40 to 45% of girls in Narok mentioned “concern that there may not be a friendly and respectful service provider”, “concern that there may not be a provider available”, “concern that there may not be a female provider available”, and “concern that other adults can see them at the clinic”. In Homa Bay, girls were more concerned about “getting money for treatment” (35%), lack of a friendly and respectful service provider (27%).

Table 8: Girls' responses about problems encountered when they want to get advice or service for SRH services, by county

Characteristic	Homa Bay n (%)	Narok n (%)
When you want to get advice or services on sexual and reproductive health (contraception, HIV services, pregnancy test), is each of the following a big problem?		
Getting permission to go	177 (16.7)	216 (27.7)
Getting money for treatment	374 (35.3)	284 (36.5)
The distance to the health facility	172 (16.2)	169 (21.7)
Having to take transport	199 (18.8)	190 (24.4)
Not wanting to go alone	212 (20.0)	277 (35.6)
Concern that there may not be female health provider	217 (20.5)	319 (41.0)
Concern that there may not be a friendly and respectful service provider	286 (27.0)	350 (44.9)
Concern that there may not be a provider	220 (20.7)	319 (41.0)
Concern that other adults can see you at the clinic	178 (16.8)	322 (41.3)

During the qualitative interviews, the girls voiced concerns about unaffordability of contraceptives (200 to 500 Kenyan shillings to access them), lack of adequate information, overstretched health

personnel and long queues at health facilities, poor attitudes of healthcare personnel, lack of qualified providers and lack of adolescent-friendly services.

*“Most of the nurses they judge – like if you go for HIV testing, the first thing they do ask is have you ever had sex, even if you haven’t and you tell them, they don’t believe you – so their judgment is always bad.”*

(Urban Narok, 19 years, University student, single with no child)

*“Even if you go to the hospital, the doctor is only one and he is very busy.”*

(IDI, rural Narok, primary school drop-out, single, no child)

*“Some of the doctors at the hospital are always very harsh, that’s why some don’t go to the hospital so what can be done is some can be taught on how to talk to the patients.”*

(IDI, rural Homa Bay, 16 year old, single with a child)

The lack of adolescent-dedicated services, according to an 18 year school drop-out girl from Mungare (urban Narok), increases the number of steps to go through before accessing the services, which breaches confidentiality:

*“No there is no privacy because you will go there just as a normal patient. When you go there you will be sent to the lab. When you go to the lab, there are many doctors there who will also know. Because you will get more than one doctor at the lab. From the lab you go to the pharmacy to get medicines, which is also stressful because you will be afraid even the doctor there will know what you are suffering from. That is the main thing”. (Urban Narok, 18 year old, single and currently pregnant)*

The lack of confidentiality means that adolescents feel shame during their time in the facilities:

*“The shame, if you go up there at the hospital, there is a problem because there are very many steps and you will be handled just like any other patients. You are sent to the lab, sent back and forth to another doctor. So there are many doctors who already know and they will be discussing you. So you don’t even know where to begin.” (Urban Narok, 18 year old, single and currently pregnant)*

### 3.6.3 Quality of care

Most of the adolescent girls interviewed in both counties were generally satisfied with the quality of services received at health facilities, especially with the health facility aspects such as availability of adequate space and waiting areas, operational hours, and convenience (Table 8). The highest ranked dimension in both counties was the adequacy of the facility space and waiting room. The youth-friendly dimensions, which are the most important for adolescents and therefore the dimensions they are more likely to be critical about, received lower rankings in both counties. Only 41% of adolescent girls in Homa Bay for instance reported that the health facility does not support adolescents to have a friend or another person with them when receiving the service, whereas in Narok, the same

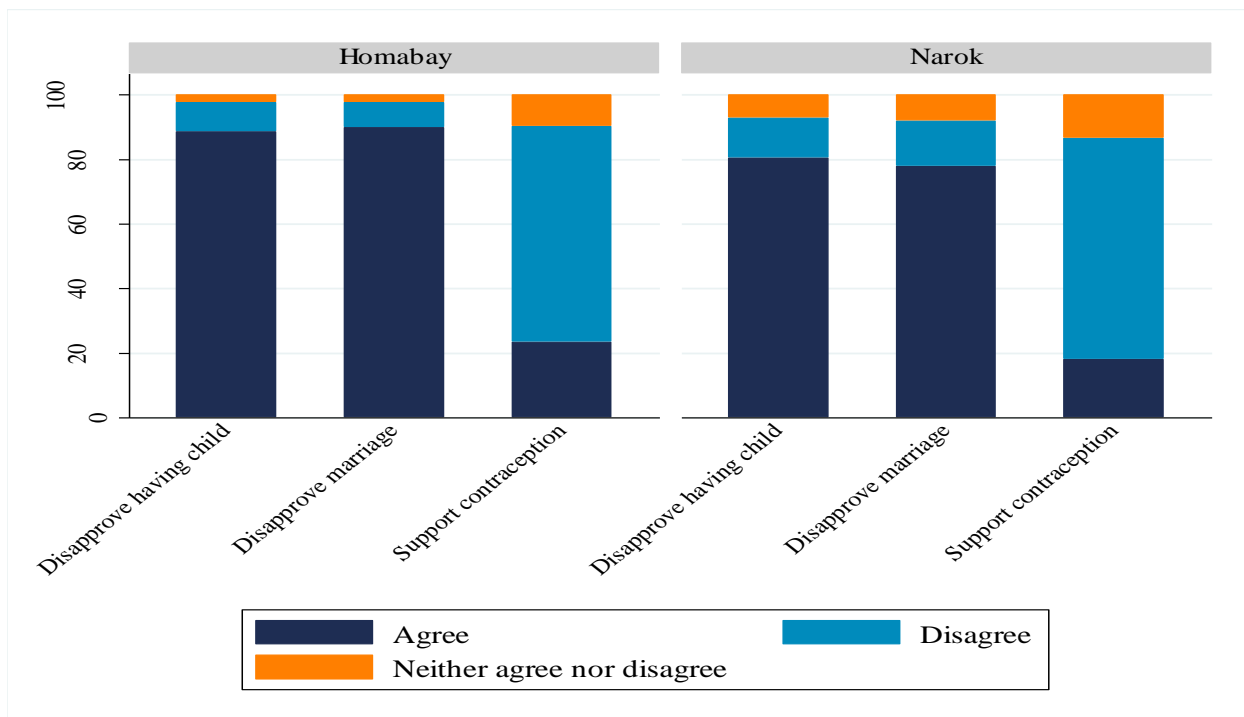
proportion of girls reported that the health facility does not have suitable appointment allocations for the needs of young people.

Table 9: Proportions of adolescent girls who responded "YES" to respective quality dimensions, by county

Quality dimension	Homa Bay N=432 n (%)	Narok N=232 n (%)
<b>Health facility aspects</b>		
Health facility has adequate space and comfortable waiting area	402 (93.1)	221 (95.3)
Service operational hours clearly advertised in a variety of locations and through a variety of media?	352 (81.5)	200 (86.2)
Service available in convenient and appropriate settings?	395 (91.4)	212 (91.4)
<b>Youth-friendly services</b>		
Service tailored to young people	355 (82.2)	151 (65.1)
Service supports adolescents to have a friend or other person with them when receiving the service?	252 (58.3)	149 (64.2)
Service has suitable appointment allocation for needs of young people	356 (82.4)	136 (58.6)
<b>Intention to come back or refer the facility</b>		
Will return to that facility	428 (99.1)	226 (97.4)

### 3.7 Parental engagement and support for adolescent SRH

The qualitative study conducted with parents, community health volunteers and adolescents assessed perspectives on the extent and role of parents and the community in adolescent SRHR issues. In the survey with adolescents, respondents were asked whether they agreed or disagreed to three key questions related to parental support for adolescent SRHR issues. Figure 19 shows that the majority of parents disapprove marriage and child bearing before completing school but paradoxically only 20% of adolescents reported that parents support adolescents' use of contraception.



**Figure 11: Adolescents' views on parental support for adolescent SRHR**

In the qualitative study parents, CHVs and adolescents considered low and inadequate parental involvement as a factor contributing to the SRH challenges faced by adolescents. Low parental engagement is evidenced by the lack of, or inadequate parent-adolescent discussions. Adolescents indicated facing difficulties in talking to their parents as they tend to be harsh.

*"If the parent is harsh, you can be afraid of asking her some things."*

(IDI, Narok, 17, single, with one child).

Parents attributed the gap in discussing SRH issues with adolescent girls to a lack of parental skills. In addition to the taboo nature of sexual discussions lead to discomfort in talking to adolescent girls about the topic.

*"It is hard [to discuss sex and relationships with adolescent girls], issues about love between girls and boys – how will you start?"* (Parents FGD, rural Homa Bay)

Lack of time as a result of parents being busy looking for money was also considered a factor contributing to low levels of discussions between parents and adolescents. Parents however noted the difficulty of getting enough money to provide for their children, a factor they considered to be pushing adolescent girls to transactional sex.

*“Maybe also lack of advice, you may find that as parents we are very busy such that we do not have time for children, and sometimes you even gone home without food so when they find someone who provides them with hundred or two hundred shillings, they will easily give in.”* (Parents FGD, urban Narok)

Parents provided suggestions to improve parental support for adolescents to deal with the SRH challenges they face. They indicated the need to create more time to talk to adolescent girls and improve on their communication skills by fostering open and friendly communication with their children, so that adolescents would feel free to share their SRH concerns with them.

*“The parents also need to be open with their daughters so that if they are told such things she will be free to report to the mother, because if parents adopt the command way of guiding, they will never inform [the mother] of anything that she is going through.”* (Parents FGD Participant, urban Narok)

Although parents were aware of the need to create time and foster better relationships with adolescent girls, they also indicated lack of skill in doing so and suggested the need for parental capacity building through seminars. Parents in some cases viewed their low levels of education as a barrier to having SRH discussions with adolescent girls, arguing that when their daughters are better educated than themselves, they think that they know more than their parents.

*“Maybe she feels that she has gone to school but you never went so she doesn’t view you as knowledgeable enough to teach her”* (Parents FGD, rural Homa Bay).

In both communities, support for adolescent SRH was offered through actors within the community such as schools, CHVs and churches. External initiatives were uncommon and only DREAMS, a HIV-focused project was mentioned in Homa Bay. In rural Narok there were reports of a few external initiatives that had been previously established by NGOs to deal with FGM.

Overall, parents and the community have a positive perception and attitudes towards both internal (local) and external (NGO) initiatives for addressing SRHR among adolescent girls.

*“When they [CHVs] come, as a parent, I have to respond and give her the chance to talk to the child, but if she also wants to consult me, I may also wait and listen, why – because as a CHV, there are things they know about counseling which they may know more than I do as a parent. Maybe the child is free with her and can talk to her better than she can talk to me.”* (Parents FGD, rural Homa Bay).

Most community support on adolescent SRH was seen to be in the form of education and information provided at schools, churches and also through the CHVs at the community level. FGD participants reported that CHVs conduct door-to-door visits to educate young people within the community. During the home visits, CHVs reported discussing relevant topics informed by their own observations in the community. In addition, CHVs also hold community forums in both the community and schools to teach young people about SRH and distribute condoms.

*“In this community, what I can say is that there are people who counsel them – you can find that when one is free, they just sit down and look for the children with problems and one day you find that she just comes and tells you that that is not the way to live with a child, let me talk to her.”* (Parents FGD, urban Homa Bay).

CHVs also indicated supporting young people through condom distribution and proper condom use as well as linking adolescent girls to health facilities for contraceptives. They however indicated that the supply for condoms was not always consistent and sometimes there were shortages.

*“We do condom promotion and distribution, we have to train them because now we have also discovered even the bodaboda people, they should just find you with a packet of condom, they will tell you; give us that and go for another – because they know you are from the hospital. So when we carry them in our bags, there are youths who want them and we give them. About contraceptives, if a girl is willing to have it, you link up her with the facilities that do it.”* (CHVs FGD, urban Homa Bay).

Churches within the community also play a role in educating young people largely focusing on circumcision, marriage and HIV related matters.

*“Yes, for example there is that one of KAG [Kenya Assemblies of God, one of the churches operating in the area], our children go there and they are taught on many things such as standing against FGM, they are told that HIV kills. My children have gone to be taught. They have a project for creating awareness on issues like circumcision, they educate girls to say no to circumcision, you know the issue of FGM is a big issue especially here in Maasai land, for instance you can get parents are the one forcing the girl to be circumcised maybe because she did go through it as a mother and she doesn’t want her girl to miss it or even sometimes when a boy marries a girl and their parents realizes that she is not circumcised, she will be taken back to her parents to get circumcised.”* (Parents FGD, urban Narok).

Parents also indicated churches as useful in teaching parents about family life, but indicated that most family life education was focused on marriage and not on parenting.

*“The church organizes seminars to teach us how to take care of our husbands, but not on how to take care of our children.”* (Parents FGD, urban Narok)

In cases where adolescent girls get pregnant, parents indicated support by raising the child, and allowing the girl to go back to school. In both Narok and Homa Bay, this was referred to as “*kumshikia mtoto*” which means “holding the child for her”.

*“When girls give birth, their mothers take care of the babies as the girl goes back to school because nowadays it is normal for girls to go back to school after giving birth.”* (Parents FGD, rural Narok).

## 4.0 Conclusion

The objective of the study was to provide baseline information on key areas of interest to the ITH project, including adolescents' access to SRH information and services, sexual behaviors, utilization of SRH services and quality of care as well as community perceptions of adolescent SRH in Homa Bay and Narok counties. Qualitative and quantitative data were collected from adolescents, parents and community health volunteers in the two counties. The survey assessed adolescents' access to SRH information, and found that quite a large proportion of adolescent respondents received information on sexual and reproductive health issues (information about how pregnancy occurs, how pregnancy and STIs/HIV can be prevented) in the 12 months before the survey mainly from teachers (including school-based mentors), friends and the media. Health facilities, community health volunteers and parents were also sources of information albeit for a lower proportion of respondents. While parents are expected to be a good source of SRH information for their adolescents, the qualitative study showed that discussions between parents and adolescents girls indicate a strong focus on abstinence until marriage or until school completion despite a general awareness that school-going adolescents are sexually active. Overall, access to accurate information and education about sexuality and reproductive health issues are central to the promotion of sexual and reproductive health and rights of adolescents and to enable them to make informed choices on matters related to sexuality and reproductive health.

The survey also showed that knowledge of any contraceptive method is almost universal among the adolescents, although a relatively higher proportion of respondents did not know methods like the IUD, female condoms and emergency contraception even after probing. Male condoms, injectables and implants are the most commonly known methods among adolescent girls in the two counties. However, correct knowledge of the fertile period is quite low reflecting gaps in the proper understanding of when pregnancy may occur during a given menstrual cycle. Knowledge of correct methods of preventing sexually transmitted infections (STIs) and HIV/AIDS is also high, with nearly two-third of adolescents in both counties reporting condom use and abstinence as the main mechanisms to prevent STIs.

Data on adolescent decision making with regards to sexuality and contraceptive use shows that adolescents reported good levels of confidence in their ability to negotiate condom use or contraceptives with their boyfriends or partners, confidence in asking a health provider questions about contraceptive methods, and discussing about STIs/HIV and pregnancy related issues with a health provider. The majority of adolescents also provided affirmative responses to the items on self-esteem, social networks and voice, although a relatively lower proportion of adolescents reported participating in decisions.

The study showed that early sexual debut is common in the two counties. While the majority of the respondents in both counties had engaged in sex, nearly half were sexually active in the twelve months

before the survey. About 40% of girls in Homa Bay and 29% of girls in Narok have engaged in sex by age 14. Having multiple sexual partnerships is also common with 46% and 52% of respondents in Homa Bay and Narok reporting having had sex with two or more sexual partners in their lifetime. As the two counties have higher HIV prevalence, there is a need to provide tailored information on the dangers of multiple sexual partnerships and the use of condoms for preventing HIV/STI infection. As a result, pregnancy rates are relatively high in both Narok and Homa Bay counties as compared to the national level, largely due to high levels of early marriage. The survey showed that 26% of respondents from Narok and 17.6% from Homa Bay were married or in a union at the time of the survey. About half of women (25-49 years old) were married by age 19 in both counties<sup>2</sup>. In the qualitative study, adolescents reported that ‘tricks’ used by boys in romantic relationships, failure of natural contraceptive methods such as standard days method, lack of proper counselling on pregnancy prevention and adolescent-friendly services contribute to the high level of pregnancy in the counties. Many of the pregnancies, however, are unintended with 69% of girls in Narok and 83% of girls in Homa Bay who had ever been pregnant reporting that they did not want the pregnancy at the time or at all.

Contraceptive use is relatively higher among sexually active adolescents particularly in Homa Bay where nearly 60% of respondents reported using any method compared to only 36% in Narok. The contraceptive prevalence rate (CPR) – any method – among all girls was however 38% in Homa Bay and 21% in Narok. These levels of CPR are relatively high compared to results reported by 2014 KDHS (10%). Despite the relatively high CPR in both counties, the findings show that most girls use condoms which is not necessarily the most effective method for pregnancy prevention but offers dual HIV and pregnancy protection. However, disparities are observed in contraceptive use by education, rural-urban residence, age and related characteristics. The percentage of girls using condoms was particularly high among younger (15-17 years) girls in both counties. The majority of adolescents who used contraception obtained the methods from public facilities and as such rated the quality of care to be fairly good. However, qualitative data highlighted misconceptions regarding contraceptives and their utilization which could explain high levels of condom use. Modern contraceptive methods such as injectables or hormonal methods in general are seen in both counties as leading to infertility if used before child bearing. Those contraceptive methods are considered to be indicated for married woman, not for children/adolescents.

Sexually active adolescents currently not using contraception provided diverse reasons for their non-use. A considerable proportion of respondents from both counties mentioned that they have never thought about contraceptives, some reported difficulty getting the partner to use contraception while others perceived that they are not at risk of getting pregnant. Embarrassment of talking about using contraception with a provider and fear of health concerns were also mentioned as reasons for non-use. The diversity and complexity of reasons for contraceptive non-use is puzzling and calls for intensive engagement with adolescents on future planning and the importance of contraceptive

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<sup>2</sup> [https://www.afidep.org/download/Fact-sheet\\_Narok-County2.pdf](https://www.afidep.org/download/Fact-sheet_Narok-County2.pdf),  
[https://www.afidep.org/download/Afidep\\_ASRH-Homa Bay-County-Final.pdf](https://www.afidep.org/download/Afidep_ASRH-Homa Bay-County-Final.pdf)



methods. It highlights the need to provide appropriate information about contraception, pregnancy and STI prevention to change adolescents' attitudes towards contraceptives. Interestingly, three-quarters of non-users have the intention to use contraceptives in the future.

Overall, about 41% of respondents in Homa Bay and 30% in Narok reported visiting health facilities in the 12 months before the survey, largely for HIV and STI testing, family planning and antenatal care. Respondents were asked about the perceived barriers they faced in accessing SRH services. A considerable proportion of respondents mentioned 'concern that there may not be a friendly and respectful service provider', 'getting money for treatment' and 'concern that there may not be a provider available' as key barriers to accessing SRH services. In the qualitative interviews as well, the girls voiced concerns about unaffordability of contraceptives (costing 200 to 500 Kenyan shillings), inadequate information, overstretched health personnel and long queues at health facilities, poor attitudes of healthcare personnel, lack of qualified providers and lack of adolescent-friendly services. Most of the adolescent girls interviewed were generally satisfied with the quality of services received at health facilities, especially with the health facility aspects such as availability of adequate space and waiting areas, operational hours, and convenience. But, the youth-friendly dimensions such as having a friend or another person with them when receiving the service and allocation of appointments suitable for the needs of young people, which are very important for adolescents, received lower rankings in both counties. Poor user experiences can work in tandem with limited access to youth-friendly services to justify low rates of service utilization among adolescent girls.

The qualitative study indicated that parents consider issues of sex and romantic relationships as dangerous, and discussions between parents and adolescent girls tend to have a strong focus on abstinence as the most effective way to escape these dangers. There is inadequate parental involvement and support for the SRH challenges faced by adolescents. Parents attributed the gap in discussing SRH issues with adolescent girls to lack of parental skills to discuss SRH issues with the adolescents, in addition to the taboo nature of sexual discussions leading to discomfort in talking to adolescent girls. It is however interesting to note the emergence of changing perceptions and practices evidenced by CHVs distributing condoms, and opening up to contraceptive use and abortion. While these changes are minimal and such open attitudes are held by a few CHVs, they also demonstrate hope for change with concerted efforts. In addition, the gap presented by parents in terms of parenting skills in relation to SRH issues presents an opportunity to engage with them. The greatest challenge lies in navigating the socio-cultural perceptions surrounding adolescent SRH that frame adolescent sexuality and contraception.

## 5.0 Recommendations

- 1. Provide more tailored information on adolescent sexual and reproductive health and on the availability of adolescent-friendly SRH services.** Although the majority of adolescents reported receiving information on SRH, the sources are diverse and include friends and peers who may not provide accurate information. Moreover, access to SRH information varies by age, education, rural-urban residence and county. There is a need to provide age appropriate, culturally sensitive and tailored SRH information and services to adolescents. This should include information and education on the safety of contraception, timing of the fertile period during a given menstrual period, where to obtain adolescent-friendly SRH services, delaying sex and marriage and information on adolescents' decision making and negotiation skills in relationships and marriage. Such information and education should be provided through diverse channels including media and interpersonal means (trained CHVs) as well as social media.
- 2. Improving parental involvement and communication on adolescent SRHR issues.** Evidence from both the quantitative and qualitative data showed that due to societal norms and values, parents do not support adolescent sexuality, use of contraception and other SRHR needs. Parent-child communication on such issues is low and when it does occur the emphasis is on abstinence. Parents attributed the gap in discussing SRH issues with adolescent girls to lack of parental skills to discuss SRH issues with their adolescents, in addition to discomfort caused by the taboo nature of sexual discussions. Thus, programs that support and engage parents on how to communicate about sexuality, relationships and contraceptive use with their adolescents is important. As the recent WHO recommendations on parental involvement state, it is important to start from their own knowledge, misconceptions, hopes and fears [21]. For instance, media programs can start discussions on how well parents know their sons and daughters relationship status, sexual behavior and whether they have ever discussed these issues with them or not.
- 3. Improving contraceptive counselling and method mix for adolescents.** Counselling on contraceptive methods is key to providing accurate information on how contraceptive methods work, the side effects of each method and the benefits associated with them. Although contraceptive use is fairly high among sexually active adolescents in the two counties, a considerable proportion of respondents believe that contraceptives cause infertility. Condoms which are the most commonly used method, seem to have wider social acceptability. While condoms offer dual protection from HIV and pregnancy, their effectiveness depends on consistent use. It is important to provide information and counselling on all available contraceptive methods including methods that are more effective and those that provide long term protection against unintended pregnancy (Implants, Sayana Press).

4. **Improving access to under-served and rural populations.** The study showed that use of contraception and other SRH services is lower among younger adolescents, rural residents and adolescents with primary education in the two counties. In the qualitative study, adolescents mentioned the lack of money as a major barrier to seeking services as they are required to pay 200-300 KES for contraceptive services. Respondents in the survey indicated that distance, transport, availability of female providers and the availability of adolescent-friendly providers are big problems to adolescents when seeking SRH services. While ITH provides services for free and even incentivizes users, it was observed during the data collection that almost all selected ITH health facilities in the two counties are located in urban and semi-urban areas. In Narok County in particular, there were very few facilities selected for ITH intervention and all of them are located in Narok town and other towns, which marginalizes the larger part of the county that is far from the facilities. Thus, there is a need to design outreach strategies to promote service access to the rural and marginalized areas of counties.
  
5. **Promoting adolescents' decision making autonomy and agency.** Gender inequality and socio-cultural barriers pose challenges to adolescents' use of SRH services in the two counties. In the qualitative study, adolescents reported 'tricks' used by boys in romantic relationships and many adolescent girls struggle to negotiate condom and other contraceptive use with their partners. This requires a multi-sectoral intervention, however health providers and CHVs can also counsel adolescents on how to negotiate contraceptive use, engage in safe sex and promote responsible and caring relationships.

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## Annexes

### Annex 1: Knowledge of contraceptive methods in Homa Bay County by socio demographic characteristics of the respondent

Socio demographic characteristics	Any method	Any modern method	IUD	Male condom	Female condom	Daily pill	Implant	Injectable	Emergency contraception
<b>Age</b>									
15-17	98.7	87.0	31.5	95.8	55.5	75.8	82.7	84.5	35.8
18-19	99.6	96.3	63.8	98.5	74.8	89.8	93.3	94.1	61.0
<b>Residence</b>									
Urban	98.6	91.6	46.9	96.6	68.3	85.5	87.5	88.4	50.3
Rural	99.4	90.7	44.5	97.3	60.8	79.4	87.1	88.9	44.2
<b>Highest level of education</b>									
Never attended school	100.0	100.0	100.0	100.0	75.0	75.0	100.0	85.5	25.0
Primary	98.8	87.6	36.5	96.1	54.8	73.9	83.7	92.3	35.5
Secondary and above	99.4	94.9	55.4	98.0	74.2	91.1	91.3	100.0	59.8

**Annex 2: Knowledge of contraceptive methods in Narok County by socio demographic characteristics of the respondent**

<b>Socio demographic characteristics</b>	<b>Any method</b>	<b>Any modern method</b>	<b>IUD</b>	<b>Male condom</b>	<b>Female condom</b>	<b>Daily pill</b>	<b>Implant</b>	<b>Injectable</b>	<b>Emergency contraception</b>
<b>Age</b>									
15-17	94.3	58.8	17.1	89.9	23.6	54.7	48.2	68.4	24.1
18-19	99.2	90.3	59.8	98.0	48.4	81.9	87.3	93.1	57.5
<b>Residence</b>									
Urban	99.1	87.5	54.1	98.3	50.0	83.7	80.8	87.5	59.6
Rural	94.9	64.6	26.4	90.6	25.1	56.3	57.7	75.6	26.2
<b>Highest level of Education</b>									
Never attended school	96.7	83.3	46.7	90.0	40.0	60.0	80.0	86.7	33.3
Primary	95.4	63.9	25.6	91.7	24.5	60.6	56.2	74.2	26.7
Secondary and above	99.0	90.8	58.2	98.0	53.8	81.5	84.9	90.8	64.0