



**A BASELINE SURVEY ON THE KEY EXPECTED ADOLESCENT AND SEXUAL REPRODUCTIVE HEALTH OUTCOMES AMONG ADOLESCENT GIRLS (15-19) IN FOUR COUNTIES IMPLEMENTING THE BINTI SHUPAVU PROGRAM IN KENYA**

**FINAL REPORT**



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**FOR**

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### **Disclaimer**

The views and opinions expressed in this report are those of the A360 Amplify Project and do not necessarily reflect the views of the Children's Investment Fund Foundation. Any errors and omissions are the responsibility of the author(s).



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## Executive Summary

### Introduction

Access to modern contraception in sub-Saharan Africa continues to be low despite growing demand to limit births, space children, avoid unintended pregnancies and prevent unsafe abortions. Substantial progress has been made in improving coverage of contraceptive services worldwide (1), but there is still a large gap in effectively meeting the contraceptive needs and preferences of adolescents (2) (3). In Africa, Bill & Melinda Gates Foundation (BMGF) and the Children's Investment Fund Foundation (CIFF) invested in the A360 Amplify interventions in Ethiopia, Nigeria, Tanzania and Kenya which aim to improve the sexual and reproductive health of adolescent girls aged 15-19 years. In Kenya, the intervention, termed Binti Shupavu and implemented by Population Services Kenya, primarily works to increase awareness, knowledge, relevance and voluntary use of modern contraception, within a wider range of activities that support girls along their journey to improved agency and livelihoods. Through Binti Shupavu, girls have the right information and support to make decisions about their bodies and confidence about their futures.

This study, therefore, aimed to evaluate the Binti Shupavu intervention, which was co-created by Population Services International (PSI), Population Services Kenya (PS Kenya), IDEO.org, Kenya's Ministry of Health and County Departments of Health in five counties and community stakeholders in Kenya in 2021 using Human Centered Design (HCD) approaches. The specific objectives of the survey were to:

1. Determine the social, demographic and behavioral profile of adolescent girls residing in the communities affiliated with health facilities where the Binti Shupavu intervention is implemented;
2. Evaluate girls' comprehensive knowledge of modern contraceptive methods and the determinants of that knowledge;
3. Investigate the determinants of current use of modern contraceptive methods among adolescent girls in the implementation geographies;
4. Determine the factors that influence girls to appreciate the relevance of modern contraceptive methods in facilitating them to pursue and achieve their life's goals;
5. Examine the factors associated with higher contraceptive self-efficacy among the girls participating in the study
6. Determine the extent to which adolescent girls living in communities where Binti Shupavu is implemented have been exposed to Binti Shupavu and what factors determine whether one is exposed or not; and
7. Document the key influencers perceptions, knowledge, attitudes towards contraceptives and their perspectives towards contraceptive use for adolescent girls.



## Methods

This study employed a concurrent mixed-method approach consisting of qualitative and quantitative methods. Quantitative methods utilized a population-based survey targeting adolescent girls aged 18-19 or emancipated girls aged 15-17 from mapped households. Qualitative methods employed key informant interviews (KIIs), in-depth interviews (IDIs) and focus group discussions (FGDs). It was conducted in four of the five counties where the Binti Shupavu intervention was implemented in 2022, namely; Kilifi, Narok, Homa Bay and Migori.

For the population-based survey, multi-stage sampling was employed. Out of the 2,073 households mapped to identify eligible adolescents, 989 were sampled and proportionally allocated to the four counties based on the number of girls targeted by the program. In each county, four sub-counties where the Binti Shupavu intervention is implemented were then randomly selected and up to seven health facilities selected from each sub-county. Ultimately, one CHU from each facility was selected from each sampled facility. From each sampled CHU, 10 girls were selected to participate in the study. **The sample size for the qualitative component was 104 participants comprising eight FGDs (4 FGDs with adolescent girls and 4 FGDs with men who were husbands/ male partners of adolescent girls; each FGD consisting of 8 participants), 10 IDIs with adolescent girls and 30 KIIs.** The 30 KIIs were administered to community health assistants, community health volunteers, health providers, County/sub-County health managers, community leaders, husbands/partners to the adolescent girls and mothers or mothers-in-law were conducted.

Quantitative data were cleaned, analyzed descriptively and logistic and linear regression models employed to respond to the specific survey objectives. Qualitative data were analyzed inductively and deductively employing a framework analysis following the development assistance criteria (DAC) evaluation criteria to surface themes related to relevance, efficiency, effectiveness, impact and sustainability of Binti Shupavu.

## Results

### ***Social, Demographic and Behavioral Profile of girls***

**A majority (83%) of the participants were girls aged 18-19, while 17% were aged 15-17.** Three quarters were single or never married and majority had below secondary education. Over one half (56.0%) were **currently in school.** The vast majority (81%) were Protestant Christians. Forty-one (41%) of the participants had given birth prior to the survey and **87%** of these had birthed only one child. A total of 33 AGYW participated in the FGDs while five were involved in IDIs. The demographic profile of the FGD and IDI participants was similar to that of survey participants. At the time of the survey, 8.6% of the girls were pregnant. Regarding the most recent or current pregnancy, 53% of girls reported they did not intend to get pregnant when it happened. Among these, 79% reported that **they had wanted to wait and 4% said they did not want to have any/more children.** The majority (83%) of girls were eager to delay their next pregnancy for at least three



years, most desiring to wait for more than five years (31.2% wanted to wait for 3-5 years and 51.2% wanted to wait for more than five years). Nearly one third of girls had never had sex. Among sexually-active girls, sex was infrequent and 60% of girls reported that it was more than a month since their most recent sexual intercourse. Over three quarters (78.6%) of the sexually-active girls reported no perceived HIV risk despite coming from HIV-prone areas in Kenya.

### ***Adolescent girls' comprehensive knowledge of modern contraceptive methods***

Many participants (88%) knew about the existence of methods that one could use to delay or avoid getting pregnant. The injectable, implants, male condoms and pills were the most commonly known methods as reported by 68%, 63%, 41% and 37% of the girls respectively (one could report knowing more than one method). Most participants had heard of these methods during a visit to a health facility or through a friend or peer. Hospitals, clinics and health centers were cited as the places where one could obtain a method. Surprisingly A non-traditional platform for obtaining a contraceptive method in most communities is a pharmacy outlet, which was selected by 15% of girls. Computed using the demographic health surveys approach, comprehensive contraceptive knowledge was reported by 87% of girls. A higher proportion of girls had comprehensive contraceptive knowledge if they came from Narok, Homabay or Migori compared to Kilifi County, were sexually active and had higher perceived social support and agency scores.

### ***Relevance of contraceptives in achieving life goals***

Regarding the girls' perception of the relevance of contraceptives, over three quarters of girls concurred that contraceptives are vital for adolescent girls to achieve their goals, complete education and pursue a better life. The main benefits of contraceptives cited were averting an unwanted pregnancy, ensuring good health for children and improving the economic situation and well-being of the family as articulated by 78.4%, 15.7% and 14.6% of the girls respectively. When relevance was computed as a composite index, 59% of girls endorsed contraceptives as a relevant tool that can aid adolescent girls to pursue their life aspirations. In a logistic regression model, girls were more likely to see the relevance of contraceptives if (a) they came from deprived households, (b) were sexually active, (c) had comprehensive contraceptive knowledge, (d) if they themselves (not their husbands/male partners of relatives) had more control over their contraceptive decision-making, and (e) had a higher perceived score on the existence of support from her significant others.

### ***Current use of modern contraceptive methods***

The results showed that 58% of sexually-active girls had ever used a method to delay or avoid a pregnancy in their lifetime, with the implant and the male condom being the most commonly used as reported by 42% and 36% of the girls respectively. Slightly more than three quarters (79%) of those girls who had used a method previously had used it within the last 12 months. The median



age at first contraceptive use was 17 years. Among the sexually-active non-pregnant participants, 43.8% were using a method at the time of the study. The implant, male condoms and injectable in that order were the predominantly used methods and two in every three (66.9%) current users had obtained their method in a medical health facility while 13.4% had obtained their method through a pharmacy outlet. Only 46.3% of sexually-active girls used a contraceptive method during the last sexual intercourse. Irrespective of this, 86.5% of current users cited that they were satisfied with the method they were using. Only 13.7% of users were using a method covertly. Sexually-active girls cited that they were not using contraceptives because of infrequent sex (24.7%), not currently having sex (14.0%), not having a partner (12.6%), lack of access or living far from where contraceptives are offered (12.1%), were breastfeeding (8.2%) or recently had a baby (7.7%). Most non-users (61.9%) intend to use a contraceptive in the next year. Most (74.1%) of girls not intending to use in the next year expressed enthusiasm to use in the future. Current contraceptive use was predicted by were having two or more children, having comprehensive contraceptive knowledge, more frequent sex, perceiving that contraceptives are relevant for adolescent girls to attain their life goals, exposure to Binti Shupavu and a higher self-efficacy score.

#### ***Contraceptive self-efficacy, perceived social support, locus of control and agency***

Contraceptive self-efficacy was measured using a 13-item scale with a maximum score of 5 for each item. A higher score implies a higher self-efficacy. The average for the 13 items was computed for each participant and a generalized linear model employed to test any associations. A higher average score was associated with older age, coming from Narok, Migori or Homa Bay Counties, having completed primary or secondary level education, comprehensive contraceptive knowledge, perceiving that contraceptives are relevant for adolescent girls to achieve their life goals, exposure to Binti Shupavu and higher self-agency scores. Participants expressed a higher perception of the social support they would receive to use contraceptives since the median score for the scale was 2.52 (SD=0.48) range 1-3). Similarly, higher score was documented for self-agency, median was 2.2 (SD=0.5) range 1-3). The mean score of perceived locus of control for contraceptive decision making was modest with at 3.21 (SD=0.8) range 1-5.

#### ***Exposure and participation in Binti Shupavu***

Overall, a third of the girls had heard about Binti Shupavu and a quarter correctly identified the Binti Shupavu logo. Girls who saw the logo had seen it predominantly on a poster, followed by T-shirt, white coat, or on a wall. Girls who heard about Binti Shupavu had done so mainly through a health facility visit, through a friend or peer or through a CHV. Most girls had heard about Binti Shupavu in the last 3 months. A substantial number (38%) of girls who had heard about Binti Shupavu participated in its activity components. A half of participants had joined in Binti Shupavu clinics, 38% and 37% had participated in Binti Shupavu stories and classes respectively and only 10.1% had participated in Binti Shupavu community fairs. Compared to Kilifi County, more girls were exposed in Migori County. Fewer girls were exposed in Homa Bay and Narok Counties.





Migori and Kilifi counties had the highest proportions of girls reporting to have been exposed to Binti Shupavu at 48.4% and 36.0% respectively while the lowest proportions of girls reporting exposure to Binti Shupavu was recorded in Homa Bay and Narok counties at 25.2% and 27.1% respectively. Exposure to Binti Shupavu was associated with comprehensive contraceptive knowledge, a higher perceived contraceptive self-efficacy, non-Catholic religious affiliation, emancipated girls under 18 years and having had sex more than a year before the survey.

### ***Key influencers' perspectives towards contraceptive use for adolescent girls***

The salient themes emerging from the KIIs, FGDs and IDIs were; awareness of Binti Shupavu, experience with Binti Shupavu, misconceptions and perceptions about contraceptives, benefits/impact of Binti Shupavu, side effects of contraceptives, decision making about adolescent girls use of contraceptives, expectations of Binti shupavu, uptake of contraceptives, and barriers to uptake of contraceptives. The findings portrayed a pro-contraceptive use attitude by adolescent girls from the key influencers. Mothers-in-law supported the use of contraceptives to space and control the number of children that one gives birth to. In Narok County, mothers-in-law suggested that they would mobilize their adolescent girls to be taught about contraceptives. They said they could also act as promoters of contraceptives if they were trained. In Homa Bay, they even suggested that girls should start using contraceptives when they are at least 15 years old.

The KIIs, IDIs and FGDs revealed misconceptions about contraceptives across the four counties. For instance, the participants argued that the "use of contraceptives before giving birth may lead to barrenness." Others believed that the "uterus may get spoilt because of the injections". Still others explained that "if *one* swallows them (pills) and *she* is not married, it can lead to *her* uterus getting rotten". The apathy towards use of contraceptives was attributed to side effects; however, the mentioned side effects were unfounded. For instance, some participants alleged that the lubricant used in condoms can be harmful to women. A participant said that "condom has oily substance that if it gets inside, one can end up getting a wound infection". Misconceptions about contraceptives were also revealed among participants in Homa Bay County, who held mixed views on the effects of contraceptives on libido among users.

Most of the girls participating in the FGDs did not know what Binti Shupavu program was all about despite having heard of it. Only a few knew what Binti Shupavu program does or had witnessed activities where girls showcased skills acquired through the program. However, girls who participated in the IDIs were aware of Binti Shupavu, explaining that the program taught adolescent girls about goal setting, raising business capital through savings and child spacing using modern contraceptives. In Narok and Kilifi counties, the husbands who participated in both the FGDs stated that they had not heard of Binti Shupavu. In Homa Bay, most of the husbands/male partners were not aware of Binti Shupavu. The lack of awareness about the Binti Shupavu program was replicated among some mothers-in-law across the four counties. Mothers-in-law from Homa Bay reported that the adolescent girls who participated in the program were knowledgeable about





contraceptives. They expressed their displeasure with lack of close follow-ups for the girls who participate in the training sessions.

Moreover, the FGDs with mothers-in-law revealed that there are still some parents who do not approve of their adolescent girls using modern contraceptives, especially the girls who have not given birth because they think contraceptives can cause barrenness. There were a few men who supported the use of modern contraceptives to space children and they even initiated discussions about using contraceptives. This support for using contraceptives notwithstanding, some men were hesitant to accompany their wives/partners to the clinic because they felt it was embarrassing. However, most FGD male participants supported the idea of men accompanying their wives to the clinic to get a contraceptive method. Worth noting is the finding that some men had no interest in deciding about contraceptives, leaving it at the discretion of their spouses/partners. Overall, the findings show that the community has generally accepted use of contraceptives by adolescent girls but there are pockets of parents and husbands/male partners who see contraceptive use as a bad thing.

### **Recommendations**

The following are the key recommendations to the Binti Shupavu implementers. First, there is need to implement targeted demand creation by ensuring that mobilizers of adolescent girls to attend program activities can profile population segments that have a need for contraceptives. Migori County appears to be doing much better for some of the indicators of success and the program should invest in harvesting lessons of what is working there and apply these lessons to the other counties. The intervention should employ blended approaches (interpersonal and alternative channels) to reach the various segments of the adolescent girls. There are many girls who have heard or seen Binti Shupavu messages but have not participated in intervention activities. Gaining a good understanding why this happens could facilitate the program in increasing its effectiveness in reaching more girls with all the components of the intervention. **Further, community awareness creation should be enhanced to correct the misconceptions around contraceptive use.**

It is crucial that the program continues to strengthen the aspirational components of Binti Shupavu so as to awaken girls to identify their life goals and position contraceptives as a vital ingredient for them to achieve these goals. This will increase the relevance of contraceptives to girls even when they might have no immediate need and prepare them adequately since they would be in need in the future. Increasing relevance of contraceptives will increase the girls' self-efficacy in contraceptive decision making and could address the discordance between contraceptive use intentions and actual use of modern contraceptive methods.

Efforts should be done to strengthen the intervention components that influence the attitudes, knowledge and perspectives of the key influencers. From the two data sources for this survey,



there is consensus that not all stakeholders are agreeable to contraceptive use among adolescent girls and that some stakeholders wield substantial influence on the decisions girls make. Creating conducive and supportive environment components that endear to key stakeholders need to be strengthened. The program should collaborate with government stakeholders to ensure continuous supply of contraceptive commodities since girls do express a need to access the full array of methods.



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## Acronyms

A360	–	Adolescents 360
AGYW	–	Adolescent Girls and Young Women
BMGF	–	Bill & Melinda Gates Foundation
CHAs	–	Community Health Assistants
CHU	–	Community Health Unit
CHVs	–	Community Health Volunteers
CIFF	–	Children’s Investment Fund Foundation
COVID	–	Corona Virus Disease
DAC	–	Development Assistance Committee
FGDs	–	Focus Group Discussions
HCD	–	Human Centered Design
HIV	–	Human Immunodeficiency Virus
IDIs	–	In-depth Interviews
IUD	–	Intra-uterine Device
KDHS	–	Kenya Demographic Health Survey
KIIs	–	Key Informant Interviews
KNBS	–	Kenya National Bureau of Statistics
MoH	–	Ministry of Health
PS Kenya	–	Population Services Kenya
PSI	–	Population Services International
SDG	–	Sustainable Development Goal
SRH	–	Sexual and Reproductive Health
UNFPA	–	United Nations Population Fund
UNICEF	–	United Nations Children’s Fund
WHO	–	World Health Organization
WRA	–	Women of Reproductive Age



## Chapter 1: Introduction

### 1.1 Background Information

The Sustainable Development Goal number 3 (SDG 3) focuses on attaining good health and wellbeing. A key target of this goal is to achieve universal access to sexual and reproductive health (SRH) services, including family planning (FP) and the integration of reproductive health into national strategies and programs by 2030. UNFPA recognizes that adolescents and youth are disproportionately affected by inequitable access to SRH services (4). As of April 2022, it was estimated that there were 1.3 billion adolescents globally, which constitutes 16 percent of the global population. Out of the 1.3 billion adolescents, 90 percent are estimated to live in developing countries (5). Kenya has one of Africa's rapidly growing populations and the proportion of youth aged 15-24 to the overall population stands at 20%, above the world's average of 15.8% and 19.2% for Africa (6). According to the 2019 Population Census in Kenya, approximately 75% of the population was younger than 35 years. Individuals aged between 10-19 years old constituted 24.5% of the population (6). With a youthful population, service demand within all sectors, including demand for health services is quite high. Unfortunately, addressing the SRH needs of young people remains a challenge in Kenya similar to other developing countries (7).

According to the WHO, 16 million adolescents aged 15-19 give birth each year, mostly in developing countries and 23 million girls who would like to use contraceptives are not (8). Access to modern contraception in sub-Saharan Africa continues to be low despite growing demand to limit births, space children, avoid unintended pregnancies and prevent unsafe abortions. As of 2017, contraceptive use among women of reproductive age (WRA) was 36% (9). Contraceptive prevalence rates in 2017 were several times higher in Northern Africa and Southern Africa (54% and 65%, respectively) than in Middle Africa (23%) and Western Africa (20%). Contraceptive use has also been increasing rapidly in Eastern Africa. In Kenya, the modern contraceptive prevalence rate in 2022 among married women 15-49 was 57% while that of sexually-active unmarried women was 70% (10).

Substantial progress has been made in improving coverage of contraceptive services worldwide (1), but there is still a large gap in effectively meeting the contraceptive needs and preferences of adolescents (2) (3). Evidence has shown that several factors influence contraceptive uptake and consistency of use among adolescents. Therefore, consideration has to be taken to the socio-cultural environment when implementing and managing contraceptive programs (11). The International Conference on Population and Development (2019) lists restrictive laws, poorly implemented policies, reluctant providers and deeply entrenched social norms as factors affecting adolescents' ability to use contraception. Further, adolescents may not know where to obtain contraception or cannot afford services, and uptake is constrained by stigma around non-marital sexual activity, pressure to demonstrate fertility and lack of agency to make choices (2) (9).

In many countries, governments and implementing partners have begun efforts to make SRH services more youth-friendly (12). However, cultural beliefs, discriminatory practices, and stigma often impede implementation, resulting in persistent barriers to contraceptive access (13). Providing adolescents and young people with interventions becomes complex and more challenging than doing so for adults. Fortunately, there has been clamor for the design and





implementation of user-centered interventions that align with their unique needs and desires. Human centered design (HCD), an innovative and iterative process based on design thinking that involves a closer interaction between a designer and the end-users through an empathy building process taking into consideration the contextual issues has gained credence for evolving promising solutions for global health problems (14).

## **1.2 Adolescents 360 Project**

Adolescents 360 (A360), led by PSI, was a four-and-a-half-year project funded by the Bill & Melinda Gates Foundation (BMGF) and the Children’s Investment Fund Foundation (CIFF) implemented from 2016 to 2020. A360 employed a multi-disciplinary design approach including HCD to create four innovative interventions: 9ja Girls and Matasa Matan Arewa (“Married Girls of the North”) in South and North Nigeria respectively, Smart Start in Ethiopia and Kuwa Mjanja in Tanzania. The interventions aim to improve the SRH of adolescent girls primarily through increasing use of voluntary modern contraception, within a wider range of activities that inspire girls along their journey to see the relevance of contraceptives and influence their decision making. In October 2020, A360 transitioned to its follow-on program, A360 Amplify. Under A360 Amplify, CIFF facilitated the expansion of programming into Kenya and PSI partnered with PS Kenya to adapt the four interventions to the local context targeting Kenyan adolescents in five counties: Homa Bay, Migori, Kilifi, Narok, and Kajiado and developed Binti Shupavu, A360’s fifth intervention. PS Kenya spearheads its implementation in the five counties.

## **1.3 Binti Shupavu intervention**

Binti Shupavu is a girl-led and user-centered intervention, which means that it starts by understanding the spirit of her adolescence and placing her needs first. Binti Shupavu primarily works to increase knowledge, relevance and voluntary use of modern contraception, within a wider range of activities that support girls along their journey to improved agency and livelihoods. The intervention has four components: (1) Binti Clinics where girls connect with peers, learn about contraception and receive SRH service delivery, and own their own stories of growth; (2) Binti Stories where the intervention engages and educates key influencers who are closest to the girls, so that they can collaboratively address misinformation, and support the decisions girls make about their bodies and futures; (3) Binti Classes where girls undergo skills training based on their needs and choices, and; (4) Binti Community Fair where girls and those around them come together to celebrate the unique contributions of girls within their communities. Through Binti Shupavu, girls have the right information and support to make decisions about their bodies and confidence about their futures. PS Kenya collaborates with county governments and other implementers to operationalize the intervention.



## 1.4 Justification of Intervention Counties

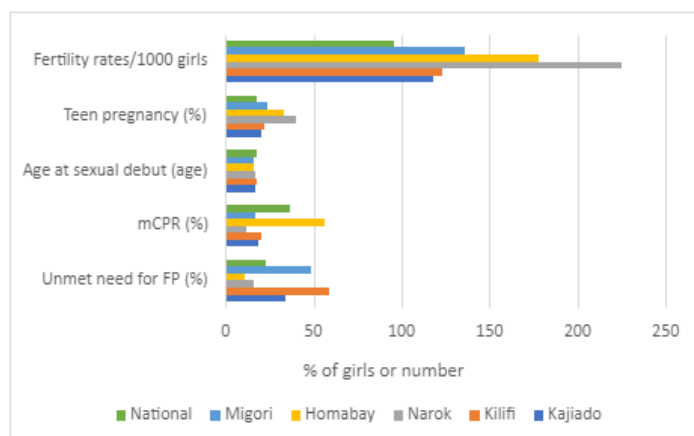


Figure 1: Key adolescent SRH indicators in the five counties

At the inception stage for the A360 Amplify project in Kenya, Kilifi, Homabay, Migori, Kajiado and Narok counties were selected to be involved in the design work for the Binti Shupavu intervention. These counties were selected because, at the time, they had the highest rates of teenage pregnancies in Kenya. Kilifi County is one of the 14 counties in Kenya considered ‘hard to reach’ for contraceptives and one of the counties with high unmet need for contraceptives among WRA at the time of implementing Binti Shupavu. The KDHS (2022) indicates that 12% of girls aged 15-19 have had a live birth (10). Similarly, in Homabay County, 26.1% of girls aged 15 to 19 were currently pregnant or had been pregnant, which is 8.2 percentage points higher than the national average of 17.9%. For Migori County, 27% of girls aged 15-19 years were reported to be currently pregnant or had ever been pregnant. Narok and Kajiado counties have some of the highest rates of teenage pregnancies in the country. In Narok, 25.9% of girls aged 15-19 have had a live birth. With this magnitude of need, these counties are most suited for implementing an innovative program that reaches adolescent girls with services that are tailored to their unique contexts.

## 1.5 Problem Statement

Access to and use of SRH services is a human right. However, uptake and utilization of SRH services remain low in many developing countries especially those in SSA including Kenya, and amongst adolescents and young people who need contraception (15). Contraceptive use among all women of reproductive age (WRA) in Kenya is estimated at 62% and 70% for married women and sexually active unmarried women respectively (10). To maximize uptake of contraception amongst adolescents and young people, evidence shows the importance of employing interventions that are user-centered to address their unique needs. Most of these interventions are co-created and implemented through adult-youth partnerships (16). The A360 program involves youth and adolescents in the design of the interventions geared at improving relevance, improving uptake and sustained use of contraception. This study therefore aimed to evaluate the Binti Shupavu intervention, which was co-developed by PSI, IDEO.org, MoH and community stakeholders in Kenya in 2021 using HCD approaches. Similar interventions have been implemented in three A360 countries (Ethiopia, Tanzania, and Nigeria) and evaluations to these interventions have yielded promising results to inform further scale up within the countries.



## 1.6 Study Objectives

The main objective of this survey was two-fold: (1) to generate baseline indicator values as part of a larger pre-post evaluation to determine the efficacy of Binti Shupavu in attaining anticipated project outcomes along the A360's logic framework and (2) document girls' and key stakeholders' perspectives towards programming for contraceptive delivery targeting adolescent girls in the counties of Kilifi, Narok, Migori and Homa Bay in Kenya. The specific objectives of this survey were to:

1. Determine the social, demographic and behavioral profile of adolescent girls residing in the CHUs affiliated with health facilities where the Binti Shupavu intervention is implemented;
2. Evaluate the girls' comprehensive knowledge of modern contraceptive methods and the determinants of the knowledge;
3. Investigate the determinants of current use of modern contraceptive methods among adolescent girls in the implementation geographies;
4. Determine the factors that influence girls to appreciate the relevance of modern contraceptive methods in facilitating them to pursue and achieve their life's goals;
5. Examine the factors associated with higher contraceptive self-efficacy among the girls participating in the study;
6. Determine the extent to which adolescent girls living in communities where Binti Shupavu is implemented have been exposed to Binti Shupavu and what factors determine whether one is exposed or not;
7. Assess key influencer perceptions, knowledge, attitudes towards contraceptives and their perspectives about contraceptive use for adolescent girls.



## Chapter 2: Methodology

### 2.1 Study Design

This study employed a concurrent mixed-method approach combining qualitative and quantitative methods. A cross-sectional design was used for the two components. Quantitative methods utilized a population-based survey targeting adolescent girls aged 18-19 or emancipated girls aged 15-17 from selected mapped households within selected Community Health Units (CHUs). Qualitative methods employed key informant interviews (KIIs), in-depth interviews (IDIs) and focus group discussions (FGDs). This was aimed at providing a snapshot of the key themes related to implementation enablers, barriers and facilitators and to surface recommendations for program improvement.

### 2.2 Study Location

This study was conducted in four counties where the Binti Shupavu intervention was implemented in 2022. These counties, namely; Kilifi, Narok, Homa Bay and Migori are justified for hosting the study because they are disproportionately affected by a higher prevalence of teenage pregnancies, adolescent marriages and lower contraceptive uptake among girls resulting from pervasive social and cultural barriers. Specifically, the study was conducted in the catchment of health facilities delivering Binti Shupavu and in community health units (CHUs) where the intervention is implemented.

### 2.3 Study population

The primary target population were adolescent girls (both married and unmarried) aged 15 to 19 who consented to be interviewed. Secondary target groups included men who were sexual partners or husbands to adolescent girls, mothers and mothers-in-law of adolescent girls, religious and opinion leaders, health care providers, community health assistants (CHAs), community health volunteers (CHVs) and peer educators.

### 2.4 Sampling methods

#### 2.4.1 Population based survey

This survey was powered to detect a 10% change in the percentage of girls reporting the relevance of contraceptives to pursuing their life goals between the current survey and an endline survey 18 months later (in 2024). Relevance was determined by calculating the proportion of girls who agreed with three statements “*using a method to avoid, delay or space pregnancies is beneficial to married adolescent girls in achieving their life goals*”, *Using contraceptive can allow a girl to complete her education, find a better job and have a better life*” and “*Using contraceptive can allow a girl achieve her life goals*” and reporting more than one valid benefit of using contraceptives. We comprehensively searched literature and did not establish published studies on using relevance as an outcome measure. However, based on unpublished studies conducted by A360, we established that 80% of adolescent girls who had actively engaged with the A360



interventions in Tanzania and Nigeria agreed with one of these statements.

Because this study was conducted at the population level, we projected modest effects and assumed that if 50% of eligible adolescent girls in the intervention CHUs would agree with this statement at the baseline, then girls in the same CHUs would report a higher relevance of contraceptives at 60% after 18 months. The minimum sample size of adolescent girls required at each point to detect the projected effect at the 99% confidence level, power of 80% and an error of 0.05 and a design effect of 1.5 was 860.

We adjusted the sample size upwards to accommodate a non-response rate of 15% to 989. Based on the 2019 Population Census, on average, a girl aged 15-19 can be found in one in every four households in the four counties (18). Binti Shupavu intervention is implemented within the health system, and the community health strategy forms a good structure on which sampling procedures were built (Ministry of Health Kenya, 2020). According to the strategy, one or several villages constitute a CHU depending on population density. Ontita and Chitere put the number of households in a village at between 50 and 250. Thus, a typical village on average yields 100 households (17). This means that each village was able to yield 40 girls based on the pilot household mapping results. However, since only 25% of girls would be in need of a contraceptive (i.e., were sexually active or married), we estimated that a village would only yield 10 eligible participants. The overall projected population of girls aged 15-19 targeted in the four counties was 131,217.

### **Household mapping procedures and outcomes**

The household mapping and listing activity involved making an in-person visit to each selected CHU to create a map that represented all the households within the CHU and to record a description of each household. Two enumerators, a mapper and a listing one, were appointed and trained to perform the mapping and listing. Households living in institutions (prisons, learning institutions, hostels, dormitories, and orphanages) were excluded from the mapping exercise and the evaluation.

The procedure of mapping the households started with locating the boundaries of each CHU and preparing the sketch map, then identifying the starting household. Upon arrival at a household, the mappers sought permission from the household heads and placed a sticker or used a marker to write on the door, or frame of the entrance to the main structure. This number was assigned to the structure on the sketch map. Mappers ensured that all structures within the cluster boundaries were covered and listed in sequential order. The listers then completed the Household Listing Form on Survey CTO and ensured that all households in the CHU/village were recorded. Overall, 2,073 households distributed as 515, 565, 704 and 289 for Homabay, Kilifi, Migori and Narok counties respectively that had adolescents aged 15-19 were mapped. Among these, 989 households comprising 314, 146, 430 and 99 from Homa Bay, Kilifi, Migori and Narok counties respectively were sampled (see Annex 1: Sample distribution for the population-based survey).





### **Sampling of CHUs/villages**

A multi-stage sampling was used. The 989 girls were proportionally allocated to the four counties based on the number of 15–19-year-old girls targeted by the program. **In each county**, four sub-counties were then sampled based on the rural/urban strata; two rural and two peri-urban/urban. Using this criterion, the sub-counties sampled were Kilifi (Malindi, Magarini, Kaloleni, Kilifi North), Homa Bay (Homa Bay, Karachuonyo, Mbita, Suba South, Ndhiwa\*), Migori (Kuria West, Kuria East, Uriri, Suna East, Suna West\*) and Narok (Narok North, Transmara East, Narok West, Narok South). To make up for the shortage of active health facilities in Suba South and Suna East in Homa Bay and Migori counties respectively, the sub-counties marked with asterisk (\*), that is, Ndhiwa and Suna West, were added.

All the health facilities within urban and rural sub-counties were listed and numbered. Then a random number generator was used to select health facilities from each category. For instance, in Narok County, 33 facilities were listed in the urban and peri-urban sub-counties, namely Narok North and Narok West respectively. Similarly, 30 health facilities were listed from the rural sub-counties of Trans-Mara East and Narok South. **Depending on the volume of girls targeted, three to seven facilities** were then selected from each sub-county using a random number generator. One Community health unit (CHU) was selected for each facility. Where multiple CHUs were served by one health facility, a CHU was randomly sampled; otherwise, where the health facility served only one CHU, that CHU was automatically selected for the study. A breakdown of the sampled facilities and CHUs is provided in Annex 2 and the list of the facilities and CHUs is also annexed to this report.

### **Participant sampling**

The primary sampling unit for the data collection component was a household already mapped to have a resident girl meeting the eligibility criteria (adolescent 18-19, 15-17 married or teen mother). From each sampled CHU, 10 girls were selected from the list of mapped eligible households to participate in the study. CHVs affiliated with these CHUs/villages aided in tracing the mapped households where potentially eligible girls could be found. Mapped households were visited consecutively until the sample size of 10 was attained.

#### **2.4.2 Qualitative study**

The qualitative methods employed purposive sampling procedures. This involved selecting individuals who were actively engaged in the Binti Shupavu intervention and who were likely to yield relevant but substantial information to meet the study objectives. We conducted four (4) FGDs involving adolescent girls, three (3) FGDs with men who were husbands/ partners of adolescent girls and one (1) FGD with mothers/mothers-in-law to the adolescent girls. Each FGD consisted of a maximum of eight (8) participants, giving 64 participants. We also conducted 10 IDIs with adolescent girls and 27 KIIs involving the following key influencers: CHAs, CHVs, health providers, County/ sub-County health managers, community leaders and mothers or





mothers-in-law. This resulted in 101 participants for the FGDs, IDIs and KIIs combined. Annex 3 summarizes the distribution of the participants by county for the FGDs, KIIs and IDIs.

## **2.5 Data collection tools**

The survey was conducted using an interviewer-administered questionnaire. The questionnaire consisted of structured questions with socio-demographic and behavioral questions, questions on contraceptive intentions, past, current, and future contraceptive use behaviors, and four likert scales. The scales were on perceived contraceptive self-efficacy (13 questions), perceived locus of control of reproductive health decision-making (six questions), perceived social support (four questions), and self-agency (five questions). The first two likert scales had five answer options: 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree and 5 = strongly agree. Self-agency and social support were responded using three answer options: 1 = not at all/a little true, 2 = moderately true and 3 = very true. FGDs, IDIs and KIIs were moderated using standard facilitation guides with core and probing questions designed to understand the perceptions towards and experiences with Binti Shupavu and knowledge, attitudes and perceptions towards contraceptives and their use by adolescent girls. All study tools were translated into Kiswahili and the interviewers were encouraged to ask the questions in the preferred local language for the participants including Dholuo for Homa Bay and Migori, and Maasai for Narok counties.

## **2.6 Data collection procedures**

Different data collection approaches were applied for the different study components. The procedures for each sub-study are detailed as follows:

### **2.6.1 Population-based survey**

After arriving at a household where an eligible girl was resident, permission was sought from the household or the most senior member of the household available at that time. The female enumerators requested to speak to the eligible girl listed on the mapping and listing form. Detailed consenting procedures were conducted within a location in the household that offered auditory and visual privacy before starting the interview. Enumerators reassured the participants of confidentiality before proceeding to execute data collection. The questionnaire was built on SurveyCTO and fielded using password-protected electronic devices (tablets) owned by PS Kenya. Data could then be submitted to the protected servers hosted at PSI and PS Kenya office/cloud. It took approximately 30 minutes administer the survey.

### **2.6.2 Qualitative interviews**

The FGDs, IDIs and KIIs were conducted in private rooms/area at the health facilities or community venues convenient to the participants. Community venues included churches and social halls or areas within the facility carefully selected to serve as “safe spaces” where girls felt comfortable and safe to meet. On the dates for data collection, a qualitative researcher and a note



taker arrived at the venue 30 minutes before the scheduled time. Once participants arrived, the qualitative researcher performed COVID-19 prevention and consenting procedures and provided basic instructions on how the FGD, IDI or KII would be conducted. Once the participant(s) were ready, they proceeded and moderated the interview or discussion. All FGDs, KIIs and IDIs were audio-recorded. Upon completion, the qualitative team immediately downloaded the audio file into a password-protected computer, named it based on agreed nomenclature and both audio and transcript files were uploaded to a secure folder on PS Kenya's SharePoint then deleted the audio record from the recorder and computers. Participant socio-demographic details were collected using a scripted questionnaire on SurveyCTO and submitted to the servers hosted by PSI/PS Kenya. The collected data was then analyzed. All handwritten notes and other hardcopy documents such as signed consent forms were placed in sealed envelopes and deposited with the field supervisors on the same date.

## **2.7 Data analysis**

### **2.7.1 Analysis of quantitative data**

Once quantitative data collection was completed, the raw dataset was downloaded and stripped of any potential identifiers. Data were then cleaned, analyzed, and presented in aggregated and inferential statistics for reporting. All analysis syntaxes, and analyses output files were archived securely. Data was summarized in proportions, means, medians, range and standard deviation. Multi-dimensional poverty index for the households where the participants came from was computed using the guidance provided by Alkire et al.(19). Since nutritional data was not feasible to collect for this survey, more weight was assigned to child mortality when developing deprivation scores.

For each of the likert scales, average scores were computed by dividing the composite score by the number of items in the scale. For the self-efficacy scale, one item was reverse coded. The scores for the self-efficacy and perceived locus of control scales ranged between 1-5 while that for the social support and self-agency ranged between 1-3. For all the four likert scales, a higher score was positive for that attribute. A participant had comprehensive contraceptive knowledge if she knew of at least one method that one could use to avoid or delay pregnancy, correctly identified one method of contraception and correctly named at least one place that one would obtain a method. Contraceptive relevance was documented if a girl met the relevance definition described in the sample size estimation criteria. Exposure to Binti Shupavu was defined as hearing about Binti Shupavu or seeing the intervention logo with or without participating in one of the program components.

For categorical outcome variables, bivariate analysis was conducted using Pearson's Chi-squared tests. Thereafter, logistic regression modeling was used to analyze the independent predictors of current contraceptive use, comprehensive contraceptive knowledge, relevance of contraceptives to



achieving life goals and exposure to Binti Shupavu. A generalized linear model (GLM) was used for analyzing the determinants of perceived contraceptive self-efficacy. Results were summarized and presented in tables and a p-value < 0.05 was considered significant.

### **2.7.2 Analysis of qualitative data**

The audio-taped interviews/discussions were transcribed verbatim and translated to English. The transcripts were reviewed for completeness and accuracy by proof reading against the audio records. Data were then coded and cleaned before being analyzed and interpreted. The data were analyzed both inductively and deductively by discovering patterns, themes, and categories at two levels. The transcripts were keenly read to examine similarities and differences between data segments and sort the data into thematic categories and sub-categories. Framework analysis method as proposed by Gale et al (2013) guided the data analysis using the development assistance criteria (DAC) evaluation criteria components relevance, efficiency, effectiveness, impact and sustainability as core themes. Upon completion of transcription, and preliminary analysis all recordings were summarily deleted. Direct quotes were employed to support the emerging themes.

### **2.8 Ethical considerations**

Several ethical considerations were made in this evaluation. These included: (a) getting administrative clearance from the respective approval authorities; (b) obtaining informed consent from all participants prior to administering tools to them; (c) protecting the confidentiality of every participant by ensuring that no identifying information was collected during individual or group interviews and storing all data in password-protected computers with access granted only to the consulting team; and (d) encouraging voluntary participation in all study activities.



## Chapter 3: Results

### 3.1 Demographic data

#### 3.1.1 Data collection outcomes

The data collection outcomes for both the population-based survey and the key influencer component are as presented in Tables 1 and 2 respectively.

**Table 1: Data collection outcomes for AGYW**

County	Sample targeted	Sample reached	Achievement rate (%)
Homa Bay	309	280	90.6
Kilifi	146	150	102.7
Migori	423	430	101.7
Narok	111	107	96.4
<b>Total</b>	<b>989</b>	<b>967</b>	<b>97.8</b>

The achievement rate of 97.8% was considered adequate for analysis. Overall, the shortage of AGYW reached in Homa Bay and Narok counties was partly compensated for by the oversampling attained in Kilifi and Migori counties.

**Table 2: Data collection outcomes for the key influencers**

County	Targeted			Achieved		
	FGDs	IDIs	KIIs	FGDS	IDIs	KIIs
Homa Bay	2	3	8	2	3	8
Migori	1	2	7	1	2	7
Narok	3	3	8	3	3	5
Kilifi	2	2	7	2	2	7
<b>Total</b>	<b>8</b>	<b>10</b>	<b>30</b>	<b>8</b>	<b>10</b>	<b>27</b>

Table 2 shows despite not attaining the targeted KIIs in Narok County, the achieved number of KIIs, IDIs, and FGDs in all counties combined met the saturation threshold of three to six focus discussions or interviews (20).

#### 3.1.2 Participant Demographics

##### 3.1.2.1 Social, Demographic and Behavioral Profile of the AGYW



Overall, 967 participants were successfully involved in the quantitative population-based study and completed the survey. The characteristics of these adolescent girls are summarized in Table 3.

**Table 3: Participant characteristics (n=967)**

Variable	Categories	Frequency	%
County			
	Kilifi	150	15.5
	Homa Bay	280	29.0
	Migori	430	44.5
	Narok	107	11.1
Age (in completed years)			
	15	22	2.3
	16	49	5.1
	17	91	9.4
	18	440	45.5
	19	365	37.7
Marital status			
	Single/never married	742	76.7
	Married or living as if married	213	22.0
	Divorced or separated	12	1.2
Highest level of education completed			
	Primary school - not completed	130	13.4
	Completed primary school	610	63.1
	Secondary or higher education	227	23.4
Occupation			
	Student	542	56.0
	Farmer/peasant	45	4.7
	Housewife	121	12.5
	Employed	83	9.0
	Unemployed	172	17.8
Religion			
	Christian- Catholic	136	14.1
	Christian- Protestant	782	80.9
	Muslim	39	4.0
	Traditional/other	10	1.0
Has EVER given birth			
	No	568	58.7
	One child	348	36.0
	Two or more children	49	5.1



As shown in Table 3, 83.2% of the girls were aged 18-19, three quarters were single or never married and 87% had completed primary or higher education. Over one half (55%) of the adolescent girls were still students in school at the time of the survey (81% in secondary, 11% in primary and 8% in tertiary institutions). The vast majority (81%) of the girls were protestant Christians. Among all participants, 41% had given birth before. Majority (87.7%) of the parous girls had only one child. Nearly one third (30%) of parous girls had given birth before 18 years. At the time of the survey 8.6% of the girls were pregnant.

The five girls who participated in the IDI were aged 19 except one aged 16. One of the girls had a secondary level of education, two had some secondary education and the other two completed primary education. Three were married and two were single. In terms of occupation, two were housewives, two were engaged in business and one was a student. A total of 33 AGYW participated in the FGD. Of this number, seven were aged 15-17 while the majority were aged 18-19. In terms of education level, most of the girls had attained some secondary level of education, four were in secondary schools, seven had completed primary education and three had some primary level of education. Two thirds of the girls were single and a third were married. Thirteen of these girls were students while most of the non-students were either housewives or self-employed. One girl was a farmer and another a casual employee. Notable are the three girls reporting to be unemployed.

### **3.1.2.2 Demographic characteristics of the key influencers**

#### ***Husbands/male partners***

The ages of the five husbands/partners who participated in the IDIs ranged from 19 to 30 with most (three) being relatively older (26 to 30 years). All the participants except one were in monogamous marriage. Apart from two, a student and a casual employee, most were farmers. FGD participants had relatively higher educational qualifications than did the AGYW. Out of the 35 male FGD participants, 28 had post-primary education with 8 having attained some tertiary or tertiary level of education. With respect to age, most were youth with only two being aged above 35 years.

#### ***Mothers/mothers-in-law***

The mothers/mother-in-law to the AGYW were above the youthful-age bracket; only one was aged below 35. Most of them (6) had no formal education and the remaining four (4) had some primary level of education. All were in monogamous marriages and were housewives.

#### ***Other key influencers***

This category comprised the County/sub-County reproductive health coordinators, health providers, chiefs, mothers, mothers-in-laws, CHVs and youth champions. Their ages ranged from



19 to 63 with most of them aged over 35 years. Most had completed secondary and tertiary levels of education, and a few had not gone beyond primary level of education.

### 3.2 Population-based survey results

#### 3.2.1 Sexual and reproductive health behaviours

When asked about the most recent pregnancy, 53% of girls who had given birth or were pregnant reported they did not want to get pregnant then. **Among these girls**, 79% reported that they would have wanted to wait or get no more children. The majority (82.4%) of girls were eager to delay their next pregnancy for at least three years from the survey date, most desiring to wait for more than five years (31.2% want to wait for 3-5 years and 51.2% want to wait for more than five years). Many participants (87.6%) were aware of the existence of methods that one could use to delay or avoid getting pregnant. The injectable, implants, male condoms and pills were the most commonly known methods in that order. Most participants had heard of these methods during a visit to a health facility or through a friend or peer. Hospitals, clinics and health centers were cited as the places where one could obtain a method. A pharmacy outlet was selected by 15% of girls. These results are summarized on Table 4.

**Table 4: Sexual and reproductive health characteristics and knowledge**

Variable	Categories	Frequency	Proportion
When do you plan to have a child or another child?			
	In less than 1 year	36	3.7
	In 1-2 years	77	8.0
	In 3-5 years	302	31.2
	In more than 5 years	495	51.2
	Never	2	0.2
	Don't Know	13	1.3
	Missing	3	0.3
Have you ever heard about any ways that a couple can use to avoid or delay pregnancy?			
	No	118	12.2
	Yes	847	87.6
	Missing	2	0.2
Methods known (n=847) - multiple responses allowed			
	Female sterilization	2	0.2
	IUD	134	13.9
	Injectables	580	60.0
	Implants	537	55.5
	Pill	318	32.9
	Male condom	347	35.9
	Female condom	20	2.1





	Emergency contraception	49	5.1
	Standard days method	25	2.6
	Other methods	20	2.1
How did you know about the methods?			
	During Binti Shupavu events	55	5.7
	Door to door outreach by a CHV	51	5.3
	Received a call/SMS	0	0.0
	Community event/fair	66	6.8
	From a youth mobiliser	26	2.7
	From husband/partner	12	1.2
	From parent/parent-in law	53	5.5
	From a health facility visit	328	33.9
	From a friend/peer	351	36.3
	Television	20	2.1
	Radio	43	4.4
	Internet/social media	6	0.6
	Other channels	180	18.6
Where one can obtain a method to delay or avoid pregnancy?			
	Hospital	573	59.3
	Clinic	106	11.0
	Health centre	381	39.4
	Mobile clinic	12	1.2
	Nursing/maternity home	15	1.6
	CHV	10	1.0
	Traditional healer	1	0.1
	Pharmacy	148	15.3
	Kiosk/shop/market	35	3.6
	Vending machine/dispenser	25	2.6
	Friend/family member	8	0.8
	Other platforms	10	1.0
Ever discussed the methods to avoid, delay or space a pregnancy with husband/male partner			
	No	366	37.8
	Yes	321	33.2
	Has no partner	275	28.4
	Missing	5	0.5
Ever used a method to avoid or delay pregnancy among sexually-active girls (n=650)			



	No	275	42.3
	Yes	375	57.7
Method used by participant/husband/partner at first time (N=375)			
	IUD	2	0.5
	Injectables	56	14.9
	Implants	135	36.0
	Pill	6	1.6
	Male condom	156	41.6
	Female condom	1	0.3
	Emergency contraception	8	2.1
	Standard days method	8	2.1
	Other methods	1	0.3
	Missing	2	0.5
Did you stop using this method(s) at any time? (n= 375)			
	No	217	57.9
	Yes	158	42.1
Contraceptive use in the last 12 months (n= 375)			
	No	80	21.3
	Yes	295	78.7
Anyone is against your seeking services to receive methods or counseling			
	No	708	73.2
	Yes	259	26.8
Who is against seeking methods or counseling (n=259) - multiple responses allowed?			
	Friend	38	14.7
	Husband/partner	53	20.5
	Mother-in-law	17	6.6
	Mother	149	57.5
	Father	47	18.1
	Other female family member	18	6.9
	Other male family member	3	1.2
	Teacher	3	1.2
	Religious Leader	4	1.5
	Other	19	7.3
Comprehensive contraceptive knowledge	No	121	12.5
	Yes	846	87.5

Among all participants, 31.4% had never had sex. Among sexually-active girls, sex was infrequent since only 47.9% reported experiencing a sexual event weekly, and 60.2% of sexually-active girls



reported that it was more than a month since their most recent sexual intercourse. Around one in eight (81.3%) sexually-active girls reported no perceived HIV risk despite coming from HIV-prone areas in Kenya.

Slightly fewer participants had ever discussed with their male partners about the use of a method to delay or avoid a pregnancy compared to those who did not (33.2% versus 37.8%), while the rest had no partners. Nearly 58% of sexually-active girls had ever used a method to delay or avoid a pregnancy in their lifetime, the male condom followed by the implant were the predominant methods used. The injectable was at a distant third. While 42.1% of lifetime contraceptive users had stopped use at one time in their life, slightly more than three quarters of the lifetime users had used a method within the last 12 months. Further, nearly 27% of girls reported that someone close to them was against their use of contraceptives, and these were parents, their husbands or partners, or a friend.

Regarding comprehensive contraceptive knowledge, the majority (87.5%) of girls met the criteria. The independent determinants of comprehensive contraceptive knowledge are summarized on Table 5. Overall, girls were more likely to have comprehensive contraceptive knowledge if they came from Narok, Homabay or Migori compared to Kilifi County, were sexually active, and had higher perceived social support and agency scores.

**Table 5: Determinants of comprehensive contraceptive knowledge**

Variable	Category	Comprehensive contraceptive knowledge		OR [95% CI]	Sig.	Adjusted O.R [95% CI]	Sig.
		No	Yes				
County	Kilifi	47(38.8%)	103(12.2%)	Ref.		Ref.	
	Homabay	14(11.6%)	266(31.4%)	8.67[4.58;16.42]	<b>0.000</b>	12.32 [5.77; 26.28]	<b>0.000</b>
	Migori	50(41.3%)	380(44.9%)	3.47[2.20; 5.46]	<b>0.000</b>	3.05[1.74; 5.33]	<b>0.000</b>
	Narok	10(8.3%)	97(11.5%)	4.43[2.12; 9.25]	<b>0.000</b>	4.47[1.84; 10.83]	<b>0.001</b>
Age	15-17 years	21(17.4%)	141(16.7%)	Ref.			
	18-19 years	100(82.6%)	705(83.3%)	1.05[0.63; 1.74]	0.850	1.25[0.97; 1.62]	0.090
Level of education	Primary not completed	24(19.8%)	106(12.5%)	Ref.		Ref.	
	Primary	65(53.7%)	545(64.4%)	1.90[1.14; 3.17]	<b>0.014</b>	1.74[0.91;3.32]	0.096
	Secondary or higher	32(26.4%)	195(23.0%)	1.38[0.77; 2.46]	0.276	1.23[0.58;2.57]	0.590
Religion	Christian-Catholic	14(11.6%)	122(14.5%)	Ref.		Ref.	
	Christian-Protestant	96(79.3%)	686(81.3%)	0.82[0.45; 1.48]	0.512	1.43[0.74;2.77]	0.289
	Muslim/Traditional/Other	11(9.1%)	36(4.3%)	0.38[0.16; 0.90]	<b>0.028</b>	2.28[0.80;6.53]	0.124
	No	85(71.4%)	483(57.1%)	Ref.		Ref.	



Ever given birth	One Child	29(24.4%)	319(37.7%)	1.94[1.24; 3.02]	<b>0.004</b>	1.20[0.62;2.34]	0.593
	2 or More children	5(4.2%)	44(5.2%)	1.55[0.60; 4.02]	0.369	0.62[0.20; 1.94]	0.408
Frequency of sex	Weekly	22(18.6%)	203(24.3%)	Ref.		Ref.	
	Monthly	7(5.9%)	161(19.3%)	2.49[1.04; 5.98]	<b>0.041</b>	1.69[0.63;4.56]	0.296
	Half yearly	3(2.5%)	74(8.9%)	2.67[0.78; 9.19]	0.119	2.25[0.61;8.37]	0.225
	Don't know	16(13.6%)	164(19.6%)	1.11[0.56; 2.18]	0.761	0.98[0.46;2.09]	0.951
	Never had sex	70(59.3%)	234(28.0%)	0.36[0.22; 0.61]	<b>0.000</b>	0.33 [0.16; 0.68]	<b>0.003</b>
Exposure to Binti Shupavu	No	88(73.9%)	516(61.0%)	Ref.		Ref.	
	Yes	31(26.1%)	330(39.0%)	1.82[1.18; 2.80]	<b>0.007</b>	2.13[1.31; 3.47]	<b>0.002</b>
Perceived social support	Mean±SD	2.35±0.56	2.55±0.47	2.17[1.51; 3.11]	<b>0.000</b>	1.90 [1.21; 2.97]	<b>0.005</b>
Perceived self-agency	Mean±SD	1.95±0.53	2.18±0.49	2.54[1.71; 3.76]	<b>0.000</b>	1.80 [1.12; 2.88]	<b>0.015</b>

### 3.2.2 Current contraceptive use behaviors

Table 6 summarizes the current contraceptive behaviours.

**Table 6: Current contraceptive intentions and behaviors among**

Variable	Categories	Frequency	Proportion
Currently want to be using any method to avoid or delay getting pregnant or space pregnancies. (Sexually-active girls only n=650)	No	271	41.7
	Yes	377	58.0
	Don't Know	2	0.3
Currently using a method (n=650)	No	365	56.2
	Yes	285	43.8
Methods used by participants (dual method allowed)			
	IUD	1	0.3
	Injectable	55	18.2
	Implants	113	37.4
	Pill	2	0.7
	Male condom	111	36.8
	Emergency contraceptive	8	2.6
	Standard days method	12	4.0
Recency of commencing the current method			
	Less than 1 month ago	23	8.1
	1-3 months ago	56	19.6
	4-6 months ago	46	16.1



	7-12 months ago	70	24.6
	More than 1 year ago	88	30.9
	Missing	2	0.7
Where current method was obtained			
	Hospital	75	25.9
	Clinic	16	5.5
	Health Centre	103	35.5
	Mobile Clinic	3	1.0
	Pharmacy	39	13.4
	Kiosk/Shop/Market	18	6.2
	Vending machine/dispenser	3	1.0
	Friend/family member	13	4.5
	Other places	20	6.9
Method information index plus (MII+) questions			
	Was told about side effects or problems you might have with the method	122	42.8
	Was told about other methods	149	52.3
	Was told she could switch to another method	160	56.1
	Was told what to do if she experiences side effects or problems	134	47.0
	Responded YES to all the (MII+) four questions	87	30.5
Does your husband/partner know that you are currently using a method to avoid or delay getting pregnant?			
	No	40	14.0
	Yes	229	80.4
	Unsure	14	4.9
	Refused to answer	2	0.7
Are you satisfied with the method that currently you or your husband/partner are using?			
	No	37	13.0
	Yes	245	86.3
	Don't know	1	0.4
	Refused to answer	1	0.4
Why are you or your partner not using a method (multiple responses allowed)?			
	Infrequent sex	90	24.7
	Already pregnant	77	21.1
	Not having sex now	51	14.0
	Not married yet/no partner	46	12.6



	Lack of access/too far	44	12.1
	Breastfeeding	30	8.2
	Recently had baby	28	7.7
	Wants more children/trying to get pregnant	23	6.3
	Respondent opposes	23	6.3
	Others (specify)	21	5.8
	Didn't occur to me to use contraception/Didn't think of using contraception	18	4.9
	Stopped meeting my partner/boyfriend	18	4.9
	Away from spouse	15	4.1
	Partner opposes	13	3.6
	Others oppose/Religious prohibition	5	1.4
Do you think you will use a method to delay or avoid pregnancy in the next one year? (n=365)			
	No	126	34.2
	Yes	226	61.9
	Don't know	14	3.8
Do you think you will use a method to delay or avoid pregnancy at any time in the future? (n=139)			
	Yes	103	74.1%
	No	31	22.3%
	Don't know	5	3.6%
What is the main reason that you think you will not use a method any time in the future?			
	Fear of side effects	33	37.9
	No sex	25	28.7
	Not married yet/no partner	15	17.2
	Respondent is opposed	8	9.2
	Health concerns	7	8.0
	Don't occur to me to use contraception/don't think of using contraception	5	5.7
	Partner opposes	5	5.7
	Infrequent sex	3	3.4
	Wants more children/trying to get pregnant	3	3.4
	Don't like existing methods	4	4.6
	Bad experience with existing methods	1	1.1
	Other reasons	5	5.7



Regarding ongoing contraceptive intentions and behaviours, 58.0% of sexually-active participants would have preferred to be doing something to delay or avoid pregnancy. Among all sexually-active non-pregnant participants, 43.8% were using a method at the time of the study. For current users, the implant, male condoms and injectable in that order were the predominantly used methods. A third of current users had been using their method for more than 12 months since they started its use. Further, slightly more than a quarter had used the method in under a three months' period. Additionally, only 46.3% of sexually-active girls used a contraceptive method during the last sexual intercourse. Two in every three (66.9%) current users had obtained their method in a medical health facility and 13.4% had obtained their method through a pharmacy outlet. Regarding the amount of information provided at the time of starting the method, between 43-58% were informed of the side effects to anticipate, were told about other methods available, the possibility of switching between methods and what to do when they experience any side effects. Irrespective of this 86.5% of current users cited that they were satisfied with the method they were using. Only 13.7% of users were using a method covertly.

Apart from being pregnant at the time of the survey, sexually-active girls cited that they were not using contraceptives because of infrequent sex (24.7%), not currently having sex (14.0%), not having a partner (12.6%), lack of access or living far from where contraceptives are offered (12.1%), were breastfeeding (8.2%) or recently had a baby (7.7%). Majority of these girls (61.9%) expressed intention to use a contraceptive in the next year. A higher proportion (74.1%) of those who were not intending to use in the next year expressed interest to use in the future. The main reasons provided for not intending to use a method at any time in the future were fear of side effects (38%), not having sex (29%) or not being married or having a partner (18%).

The independent predictors of current contraceptive use were having two or more children, having comprehensive contraceptive knowledge, more frequent sex, perceiving that contraceptives are relevant for adolescent girls, having exposure to Binti Shupavu and a higher perceived self-efficacy score. The predictors, their unadjusted and adjusted odds ratios and the significance of these predictors are summarized on Table 7.



**Table 7: Independent predictors of current contraceptive use**

Variable	Category	Currently using Modern Contraceptive		O.R [95% C.I]	Sig.	A.O.R [95%C.I]	Sig.
		No	Yes				
County	Kilifi	32(11.1%)	28(10.0%)			n/s	n/s
	Homabay	81(28.1%)	77(27.5%)	1.09[0.60; 1.97]	0.785	n/s	n/s
	Migori	135(46.9%)	135(48.2%)	1.14[0.65; 2.00]	0.641	n/s	n/s
	Narok	40(13.9%)	40(14.3%)	1.14[0.58; 2.23]	0.696	n/s	n/s
Age	15-17 years	69(24.0%)	53(18.9%)			n/s	n/s
	18-19 years	219(76.0%)	227(81.1%)	1.35[0.90; 2.02]	0.145	n/s	n/s
Marital Status	Single	207(71.9%)	202(72.1%)			n/s	n/s
	Married	75(26.0%)	73(26.1%)	1.00[0.68; 1.45]	0.989	n/s	n/s
	Divorced/separated	6(2.1%)	5(1.8%)	0.85[0.26; 2.84]	0.797	n/s	n/s
Level of Education	Primary incomplete	44(15.3%)	40(14.3%)			n/s	n/s
	Primary	174(60.4%)	166(59.3%)	1.05[0.65; 1.69]	0.843	n/s	n/s
	Secondary or higher	70(24.3%)	74(26.4%)	1.16[0.68; 1.99]	0.583	n/s	n/s
Religion	Christian-Catholic	45(15.7%)	38(13.6%)			n/s	n/s
	Christian-Protestant	230(80.1%)	235(83.9%)	1.21[0.76; 1.93]	0.425	n/s	n/s
	Muslim/Traditional/Other	12(4.2%)	7(2.5%)	0.69[0.25; 1.93]	0.480	n/s	n/s
Ever Given birth	No	118(41.3%)	98(35.0%)			Ref.	
	One child	152(53.1%)	154(55.0%)	1.22[0.86; 1.73]	0.265	1.34[0.91; 1.98]	0.1427
	2 or more	16(5.6%)	28(10.0%)	2.11[1.08; 4.12]	<b>0.029</b>	1.79[0.84; 3.81]	0.1309
Deprived Household	No	120(41.7%)	117(41.8%)			n/s	n/s
	Yes	168(58.3%)	163(58.2%)	1.00[0.71; 1.39]	0.977	n/s	n/s
Given birth before 18 years	No	220(76.9%)	227(81.1%)			n/s	n/s
	Yes	66(23.1%)	53(18.9%)	0.78[0.52; 1.17]	0.227	n/s	n/s
Most recent sex	< 1 month ago	72(25.0%)	131(46.8%)			Ref.	
	1-3 months ago	47(16.3%)	68(24.3%)	0.80[0.50; 1.27]	0.339	0.69[0.41; 1.13]	0.142
	4-6 months ago	42(14.6%)	29(10.4%)	0.38[0.22; 0.66]	<b>0.001</b>	0.44[0.24; 0.80]	<b>0.007</b>
	7-12 months ago	66(22.9%)	29(10.4%)	0.24[0.14; 0.41]	<b>0.000</b>	0.29[0.17; 0.50]	<b>0.000</b>
	>12 months ago	61(21.2%)	23(8.2%)	0.21[0.12; 0.36]	<b>0.000</b>	0.20[0.11; 0.36]	<b>0.000</b>
Comprehensive contraceptive knowledge	No	30(10.4%)	6(2.1%)			Ref.	
	Yes	258(89.6%)	274(97.9%)	5.31[2.17; 12.97]	<b>0.000</b>	4.05[1.57; 10.42]	<b>0.004</b>
See contraceptives as relevant	No	105(36.5%)	59(21.1%)			Ref.	
	Yes	183(63.5%)	221(78.9%)	2.15[1.48; 3.12]	<b>0.000</b>	1.67[1.10; 2.55]	<b>0.017</b>
Exposure to Binti Shupavu	No	188(65.7%)	150(53.6%)			Ref.	
	Yes	98(34.3%)	130(46.4%)	1.66[1.18; 2.33]	<b>0.003</b>	1.29[0.89; 1.88]	0.185





Perceived self-efficacy	Mean±SD	3.94±0.57	4.23±0.45	3.11[2.16; 4.47]	<b>0.000</b>	2.48[1.65; 3.74]	<b>0.000</b>
Perceived self-agency	Mean±SD	2.15±0.50	2.29±0.48	1.83[1.30; 2.58]	<b>0.001</b>	1.01[0.68; 1.51]	0.946

### 3.2.3 Contraceptive relevance

Regarding the participants' perspective of contraceptive use, over three quarters of girls concurred that contraceptives are vital for adolescent girls to achieve their goals, complete education and pursue a better life. The vast majority endorsed the diverse benefits of contraceptive use by adolescent girls as depicted on Table 8.

**Table 8: Relevance of contraceptives to attaining life goals**

Variable	Categories	Frequency	Proportion
Do you agree, are neutral or disagree that using a method to avoid, delay or space pregnancies is beneficial to married adolescent girls in achieving their life goals?			
	Agree	735	76.0
	Neutral	76	7.9
	Disagree	156	16.1
Using contraceptive can allow a girl to complete her education, find a better job and have a better life			
	Agree	771	79.7
	Neutral	66	6.8
	Disagree	130	13.4
Using contraceptive can allow a girl to achieve her life goals			
	Agree	737	76.2
	Neutral	98	10.1
	Disagree	132	13.7
Benefits of contraceptives			
	Help avoid unwanted pregnancy	758	78.4
	Good for the health of children	152	15.7
	Improve the economic situation and well-being of the family	141	14.6
	Good for the health of women	131	13.5
	Reduce the risk associated with abortion	105	10.9
	No benefit	83	8.6
	Other benefits	69	7.1
	Do not know	25	2.6



Overall, 576 (59.3%) of girls viewed contraceptives as a relevant tool that can enable girls to achieve their life goals, using a composite indicator that combines the four items. In regression analysis, girls were more likely to see the relevance of contraceptives if they were older, or from Muslim or other religions, originated from deprived households, were frequently engaged in sex, had comprehensive contraceptive knowledge, perceived that they had **more** control in making reproductive health decisions and had perceived the existence of support to use contraceptives from her significant others. These findings are summarized on Table 9.

**Table 9: Independent predictors of contraceptive relevance**

Variable	Category	Contraceptives Relevance		O.R[95% C.I]	Sig.	A.O.R 95% C.I.	Sig.
		No	Yes				
Age	15-17 years	53(13.5%)	109(19.0%)	Ref.		Ref.	
	18-19 years	341(86.5%)	464(81.0%)	0.66[0.46; 0.95]	<b>0.023</b>	0.92[0.59; 1.43]	0.711
Religion	Christian-Catholic	45(11.4%)	91(15.9%)	Ref.		Ref.	
	Christian-Protestant	322(81.7%)	460(80.6%)	0.71[0.48; 1.04]	0.077	0.87[0.57; 1.32]	0.508
	Muslim/Traditional/Other	27(6.9%)	20(3.5%)	0.37[0.19; 0.72]	<b>0.004</b>	0.70[0.33; 1.50]	0.360
Ever given birth	No	266(67.5%)	302(52.9%)	Ref.		Ref.	
	One child	108(27.4%)	240(42.0%)	1.96[1.48; 2.59]	<b>0.000</b>	1.09[0.74; 1.60]	0.671
	2 or more children	20(5.1%)	29(5.1%)	1.28[0.71; 2.31]	0.419	0.69[0.34; 1.36]	0.284
Deprived household	No	203(51.5%)	231(40.3%)	Ref.		Ref.	
	Yes	191(48.5%)	342(59.7%)	1.57[1.21; 2.04]	<b>0.001</b>	1.43[1.07; 1.91]	<b>0.014</b>
Frequency of sex	Weekly	82(21.0%)	143(25.4%)	Ref.		Ref.	
	Monthly	34(8.7%)	134(23.8%)	2.26[1.42; 3.59]	<b>0.001</b>	1.78[1.07;2.91]	<b>0.022</b>
	Half yearly	27(6.9%)	50(8.9%)	1.06[0.62; 1.82]	0.828	1.04[0.58; 1.85]	0.904
	Don't know	58(14.9%)	122(21.6%)	1.21[0.80; 1.82]	0.375	1.20[0.76; 1.89]	0.435
	Never had sex	189(48.5%)	115(20.4%)	0.35[0.24; 0.50]	<b>0.000</b>	0.44[0.28;0.70]	<b>0.001</b>
Comprehensive contraception knowledge	No	76(19.3%)	45(7.9%)	Ref.		Ref.	
	Yes	318(80.7%)	528(92.1%)	2.80[1.89; 4.16]	<b>0.000</b>	1.61[1.02;2.53]	<b>0.040</b>
Exposure to Binti Shupavu	No	270(68.5%)	334(58.5%)	Ref.		Ref.	
	Yes	124(31.5%)	237(41.5%)	1.55[1.18; 2.02]	<b>0.002</b>	1.22[0.90;1.65]	0.205
Perceived locus of control	Mean±SD	3.14±0.72	3.26±0.85	1.23[1.04; 1.44]	<b>0.014</b>	2.0[1.56;2.65]	<b>0.000</b>
Perceived social support	Mean±SD	2.45±0.50	2.57±0.47	1.67[1.28; 2.18]	<b>0.000</b>	1.43[1.04;1.96]	<b>0.028</b>
Perceived self-agency	Mean±SD	2.04±0.50	2.22±0.49	2.06[1.58; 2.68]	<b>0.000</b>	1.12[0.81;1.55]	0.492



### 3.2.4 Exposure to Binti Shupavu

There were varied responses regarding exposure to Binti Shupavu and its program components. Overall, a third of girls had heard about Binti Shupavu and a quarter were able to correctly identify that they had seen the Binti Shupavu logo. Girls who saw the logo had seen it predominantly on a poster, followed by T-shirt, white coat, on a wall or through other platforms. Those who heard about Binti Shupavu had done so mainly through a health facility visit, through a friend or peer or through a CHV. Most girls had heard about Binti Shupavu recently (in the last 3 months). A substantial number (38%) of girls who had heard about Binti Shupavu participated in its activity components. More details regarding exposure to Binti Shupavu are tabulated on Table 10.

**Table 10: Exposure to Binti Shupavu**

Variable	Categories	Frequency	Proportion
Heard about Binti Shupavu			
	No	650	67.2
	Yes	315	32.6
	Missing	2	0.2
Seen the intervention logo			
	No	734	75.9
	Yes	231	23.9
	Missing	2	0.2
Where was the intervention logo seen? (n=231)			
	Poster	92	39.8
	T- shirt	45	19.5
	Lesso	7	3.0
	White coat	50	21.6
	On a wall	45	19.5
	Goal setting card	4	1.7
	Social media page	6	2.6
	Others	40	17.3
Channels through which girls heard about Binti Shupavu (n=315)			
	PS-Kenya	16	5.1
	CHV	73	23.2
	Community event/fair	40	12.7
	Youth mobilizer	32	10.2
	Parent or in law	4	1.3
	Health facility visit	80	25.4
	Friend/peer	70	22.2
	TV/radio/social media	42	13.3
	Community leader	10	3.2
	Others	20	6.3
Recency of awareness (n=315)			
	< 3 months	168	53.3
	4-6 months	67	21.3



	7-12 months	71	22.5
	> 12 months	9	2.9
Participation in Binti Shupavu activities (n=315)			
	No	196	62.2
	Yes	119	37.8
What did you participate in? (n=119)			
	Binti Shupavu stories	45	37.8
	Binti Shupavu clinic	59	49.6
	Binti Shupavu classes	44	37.0
	Binti Shupavu fair	12	10.1
	Other activities	9	7.6

Compared to Kilifi County, more girls were exposed in Migori County and fewer girls were exposed in Narok and Homa Bay counties. Having been exposed to Binti Shupavu was associated with comprehensive contraceptive knowledge, a higher perceived contraceptive self-efficacy and self-agency, non-Catholic religious affiliation, and no recent sex. The results for the predicted determinants of exposure to Binti Shupavu are summarized on Table 11.

**Table 11: Independent predictors of exposure to Binti Shupavu**

Variable	Category	Exposed to Binti Shupavu		O.R[95% C.I]	Sig.	A.O.R 95% C.I.	Sig
		No	Yes				
County	Kilifi	96(15.9%)	54(15.0%)	Ref.		Ref.	
	Homabay	208(34.4%)	70(19.4%)	0.60[0.39; 0.92]	<b>0.019</b>	0.32[0.19; 0.53]	<b>0.000</b>
	Migori	222(36.8%)	208(57.6%)	1.67[1.14; 2.44]	<b>0.009</b>	0.96[0.60; 1.52]	0.853
	Narok	78(12.9%)	29(8.0%)	0.66[0.38; 1.14]	0.134	0.36[0.20;0.67]	<b>0.001</b>
Age	15-17 years	90(14.9%)	70(19.4%)	Ref.		Ref.	
	18-19 years	514(85.1%)	291(80.6%)	0.73[0.52; 1.03]	0.070	0.68[0.46; 1.01]	0.054
Religion	Christian-Catholic	71(11.8%)	65(18.1%)	Ref.		Ref.	
	Christian-protestant	500(82.9%)	280(77.8%)	0.61[0.42; 0.88]	<b>0.009</b>	0.56[0.38;0.83]	<b>0.004</b>
	Muslim/Traditional/ Other	32(5.3%)	15(4.2%)	0.51[0.25; 1.03]	0.061	0.43[0.19; 0.95]	<b>0.038</b>
Recency of last sex	< 1 month ago	153(25.3%)	111(30.7%)	Ref.		Ref.	
	1-3 months ago	70(11.6%)	54(15.0%)	1.06[0.69; 1.64]	0.780	1.11[0.70; 1.77]	0.655
	4-6 months ago	47(7.8%)	35(9.7%)	1.03[0.62; 1.69]	0.919	1.34[0.78; 2.32]	0.286
	7-12 months ago	65(10.8%)	40(11.1%)	0.85[0.53; 1.35]	0.486	0.89[0.54;1.46]	0.632



	> 12 months ago	62(10.3%)	24(6.6%)	0.53[0.31; 0.91]	<b>0.020</b>	0.49[0.28; 0.87]	<b>0.015</b>
	Never had sex	207(34.3%)	97(26.9%)	0.65[0.46; 0.91]	<b>0.013</b>	0.88[0.59; 1.30]	0.512
Comprehensive contraceptive knowledge	No	88(14.6%)	31(8.6%)	Ref.		Ref.	
	Yes	516(85.4%)	330(91.4%)	1.82[1.18; 2.80]	<b>0.007</b>	1.92[1.19; 3.10]	<b>0.007</b>
Perceived risk of contracting HIV	Low	513(84.9%)	300(83.1%)	Ref.		Ref.	
	Moderate	59(9.8%)	42(11.6%)	1.22[0.80; 1.85]	0.359	1.03[0.66; 1.63]	0.883
	High	32(5.3%)	19(5.3%)	1.02[0.57; 1.82]	0.959	0.82[0.44;1.52]	0.521
Perceived self-efficacy	Mean±SD	3.95±0.64	4.16±0.61	1.55[1.18; 2.02]	<b>0.002</b>	1.74[1.34; 2.27]	<b>0.000</b>
Perceived self-agency	Mean±SD	2.12±0.51	2.19±0.50	1.30[1.00; 1.69]	<b>0.048</b>	0.84[0.61; 1.15]	0.268

### 3.2.4 Contraceptive self-efficacy

The construct of contraceptive self-efficacy was measured to assess how much confidence or self-belief girls had regarding their ability to access contraceptive methods at service delivery points, speak to providers about their needs and preferences and persuade their partners to use contraceptive methods. The responses to each individual item are summarized on Annex 4 in the appendices. The participant's mean score was 3.95 (interquartile range = 0.77). Given that the minimum score is 1 and maximum score is 5, this implies that most girls exude confidence in being able to meet their contraceptive needs and preferences. A higher average self-efficacy score was associated with older age, coming from Narok, Migori or Homabay Counties, having completed primary or secondary level education, having comprehensive contraceptive knowledge, perceiving that contraceptives are relevant for adolescent girls, being exposed to Binti Shupavu and a higher self-agency score. Table 12 summarizes the independent predictors of perceived self-efficacy as established by a GLM.

**Table 12: Independent predictors of perceived self-efficacy**

Variable	Category	Beta [95% C.I]	Sig.	Adjusted Beta [95% C.I]	Sig.
Age (in years)		0.05[0.01; 0.09]	<b>0.026</b>	0.02[-0.09;-0.01]	0.074
County	Kilifi	Ref.		Ref.	
	Homabay	0.47[0.34; 0.59]	<b>0.000</b>	0.39[0.26;0.52]	<b>0.000</b>
	Migori	0.51[0.39; 0.62]	<b>0.000</b>	0.41[0.29;0.53]	<b>0.000</b>
	Narok	0.28[0.13;0.43]	<b>0.000</b>	0.23[0.08;0.39]	<b>0.003</b>
Level of Education	Primary not completed	Ref.		Ref.	
	Primary	0.29[0.17;0.41]	<b>0.000</b>	0.17[0.05;0.30]	<b>0.005</b>



	Secondary or Higher	0.32[0.18;0.46]	<b>0.000</b>	0.28[0.08;0.36]	<b>0.002</b>
Religion	Christian-Catholic	Ref.		Ref.	
	Christian-Protestant	-0.11[-0.23; 0.01]	0.061	-0.09[-0.19;0.02]	0.102
	Muslim/Traditional/Other	-0.47[-0.68;-0.26]	<b>0.000</b>	0.02[-0.18;0.23]	0.839
Ever given birth	No	Ref.		Ref.	
	One child	0.20[0.12;0.28]	<b>0.000</b>	0.04[-0.06;0.14]	0.401
	2 or more children	0.21[0.02;0.39]	<b>0.029</b>	0.03[-0.16;0.21]	0.791
Frequency of sex	Weekly	Ref.	<b>0.001</b>	Ref.	
	Monthly	0.21[0.09;0.33]	0.910	0.11[-0.01;0.23]	0.083
	Half yearly	-0.01[-0.17;0.15]	0.413	-0.04[-0.19;0.12]	0.655
	Don't know	-0.05[-0.17;0.15]	<b>0.000</b>	0.07[-0.06;0.19]	0.294
	Never had sex	-0.32[-0.43;-0.22]	<b>0.001</b>	-0.03[-0.17;0.11]	0.687
Comprehensive contraceptive knowledge	No	Ref.		Ref.	
	Yes	0.42[0.31;0.54]	<b>0.000</b>	0.060[-0.06;0.18]	0.324
Perceived risk of contracting HIV	Low	Ref.		Ref.	
	Moderate	0.16[0.03;0.29]	<b>0.018</b>	0.05[-0.07;0.17]	0.408
	High	-0.02[-0.20;0.16]	0.830	0.07[-0.09;0.24]	0.392
See contraceptives as relevant	No	Ref.		Ref.	
	Yes	0.38[0.31; 0.46]	<b>0.000</b>	0.20[0.12;0.28]	<b>0.000</b>
Exposure to Binti Shupavu	No	Ref.		Ref.	
	Yes	0.21[0.12;0.29]	<b>0.000</b>	0.14[0.06;0.22]	<b>0.000</b>
Perceived locus of control		-0.06[-0.11; -0.01]	<b>0.029</b>	-0.03[-0.08; 0.02]	0.188
Perceived social support		0.22[0.14; 0.30]	<b>0.000</b>	0.04[-0.05;0.12]	0.379
Perceived self-agency		0.417[0.341; 0.492]	<b>0.000</b>	0.29[0.21;0.37]	<b>0.000</b>

Finally, we asked adolescent girls some questions to decipher if they held common descriptive norms about contraceptives in their communities. We established that only 30% of girls agreed that most men married or living with adolescent girls as if married discussed contraceptives in their communities. Only 34% endorsed that adolescent girls in their vicinity were using a method to avoid or prevent pregnancy. Surprisingly, 30% agreed that they believed that adolescent girls in



their community were using a method discreetly from their male partner or husband. Further, 33.9% of participants disapproved that adolescent girls should use contraceptives. In addition, 31.2% still disapproved of the use of contraceptives by a couple involving an adolescent girl. These results are described in Annex 7.

### 3.3 Qualitative Results

The qualitative component of this report addresses the key influencer perceptions, knowledge, attitudes towards contraceptives and perspectives towards contraceptive use for adolescent girls. This section begins with reporting on the perceptions, knowledge and attitudes of key influencers towards contraceptive use for adolescent girls followed by community expectations from the program and a thematic presentation of the evaluation results based on five evaluation criteria namely relevance, effectiveness, efficiency, impact and sustainability.

#### 3.3.1 Knowledge, Perceptions and Attitudes towards Binti Shupavu

Most of the girls who participated in the FGDs did not know what Binti Shupavu program was all about despite having heard of it. Only a few knew what Binti Shupavu program does or had witnessed activities where girls showcased skills acquired through the program. This was not only observed in Narok and Kilifi counties but was replicated in Homa Bay and Migori counties. However, the IDI adolescent participants were aware of Binti Shupavu, explaining that the program taught adolescent girls about goal setting, raising business capital through savings and child spacing using modern contraceptives. With regards to who the program targeted, participants explained that it targeted AGYW as accentuated by an FGD, that is, "*Binti Shupavu targets young girls who got pregnant while still young, the young ones who got married before finishing school*"

In Narok and Kilifi counties, the husbands who participated in the FGDs and IDIs stated that they had not heard of Binti Shupavu. Similarly, in Homa Bay, most of them were not aware of Binti Shupavu. The lack of awareness about the Binti Shupavu program was replicated among mothers-in-law across the four counties and the few who knew were unable to divulge more information about the program.

The participant girls in Narok County reported that although they had been exposed to knowledge through the program, they were not happy with lack of close follow-ups after the training sessions. An IDI participant lamented:

At some point we saw that we had attended a lot of meetings but there weren't people (doctors) coming to check up on us. We are always by ourselves every day...we were being told that they (doctors) might come the following week but when that week comes they are nowhere to be found (AGYW IDI participant, Narok)





In concurrence with the girls, the mothers-in-law reported that the program held a few meetings with the girls but stopped abruptly in Narok County. According to an FGD participant:

It was the girls that were being taught about contraception...They were mostly targeting the young mothers who gave birth and they didn't go back to school. I have a daughter who gave birth and she was not able to go back to school due to problems at home. We felt like that program would have been of help, but those people involved didn't come back to the community, because I would have received a call (Mother in-laws FGD, participant, Narok)

The program seems to have positively impacted their self-efficacy as well as gaining essential skills. The FGD participants had a good experience with the program because they were taught many skills such as *"how to abstain"*, *"how to use contraceptives"* and *"how to take care of themselves"*. They also explained that at the beginning, they could not publicly talk about contraceptives but the awareness provided made them comfortable having these discussions. A participant stated, *"It became interesting, we could even now laugh because we became comfortable."* They also felt that the mentors showed them a lot of respect which made them comfortable to undergo the training. A participant noted:

When we would hear people are coming to talk about contraception at this age, we were scared at first because it felt like a subject that should be discussed privately and not publicly; but how they handled us made us feel comfortable (AGYW FGD participant, Narok)

This was reiterated by the IDI participant who explained that *"all the mobilizers were friendly, services offered were good, and handled us well."* The lessons on modern FP methods enabled the girls to make a choice about the methods that suit them best. An IDI participant stated, *"Yes it (training on modern contraceptive methods) was important because there were some girls who did not like the insertion method, so others chose the methods that suits them."* Confirming these benefits, mothers-in-law from Homa Bay reported that the adolescent girls who participated in the program were knowledgeable about contraceptives. A participant noted, *"My girl has learnt a lot of because now she knows all types of contraceptives, signs and symptoms of certain diseases"* However, some of the hoped-for skills training were not conducted to the disappointment of some of the girls as articulated by the IDI participant who reported that *"the challenge that I had was interested in baking cake but that program did not go forth and did not bake."*

### **3.3.2 Knowledge, Perceptions and Attitudes towards contraceptives**

The interviews and focus discussions with adolescent girls revealed misconceptions about contraceptives. For instance, the participants argued that the *"use of contraceptives before giving birth may lead to barrenness."* Others believed that the *"womb may get spoiled because of the*



*injections*". Still others explained that "if one swallows them (pills) and she is not married, it can lead to her womb getting rotten" Some participants alleged that the lubricant used in condoms can be harmful to women. A participant said that "condom has oily substance that if it gets inside, one can end up getting a wound infection". Misconceptions about contraceptives were also revealed among participants in Homa Bay County, who held mixed views on the effects of contraceptives on sexual urge among users. For instance, a participant explained:

Some people say that when you use contraceptives, you are just the way you are, even when someone is touching you, ... and some say that there are some contraceptives which when you use; you become more active towards sex (AGYW FGD participant, Homa Bay)

Some community members believed that modern contraceptive methods cause barrenness and trigger irresponsible sexual behavior among AGYW since they get to know that they cannot get unwanted pregnancies while forgetting about the Sexually Transmitted Infections. According to one of the religious leaders, some community members believe that modern contraceptive methods make people sick and can even kill a person, If the misinformation about contraceptive methods is not addressed, it will run counter to the program's efforts of increasing contraceptive uptake among the target group.

Husbands seemed to favour the adolescent use short-term FP methods over the long-term ones. An FGD participant in Narok County reported that "*contraceptive use may result in difficulty in bearing children. Although men support use of contraceptives, they prefer short term methods due to fear that the longer-term methods can cause infertility*". Some men believed that use of contraceptives, especially the long-term methods can easily result in the woman being unfaithful, more so, if their husbands work/live far away. The fear of unfaithfulness among women using long term FP methods also surfaced in Kilifi County with men saying that women on long term FP methods can take advantage of husband's long absence to cheat in marriage. Others perceived contraceptives to cause infertility in women as narrated in this excerpt:

After using contraceptives, one goes for around five years without getting her periods which becomes a problem...I think if they don't get their periods, it may affect their reproductive organs. So you find that you can only give birth to one child... (Husband FGD participant, Narok).

Nonetheless, the findings revealed that there are a few men who support the use of modern contraceptives to space children and they even initiate discussions about using contraceptives. An IDI participant affirmed, "*I discussed it with her (my spouse) until we came to a decision that we should use this method of contraceptives...In fact, I was the one who initiated it*" This support for using FP methods notwithstanding, men still were hesitant to accompany their wives to the clinic because they feel it is embarrassing. An IDI participant emphatically reported that: "*men find it hard to accompany their partners. Let the woman go on her own...It looks embarrassing... There*



*is this notion that a woman should walk on her own”* This was reiterated in the FGD where a participant explained that *"to a larger extent, a man accompanying his wife to the health facility will be ridiculed by other members of the community. He will not be considered a total man."*

Worth noting is the finding that some men had no interest in deciding about contraceptives, leaving it at the discretion of their wives/female partners. This was brought out in the interview with a male participant who explained:

In this community, men are not even concerned with family planning; only women who plan themselves. So, if a woman does not plan for herself, she will find herself giving birth to children who follow each other. The decision is made by the woman only (Husband FGD, Narok)

The disinterest of men in matters of family planning was also reported in Kilifi County. However, most FGD participants supported the idea of men accompanying their wives to the clinic to get a contraceptive method. One participant stated:

Accompanying your wife to a dispensary is a good thing so that you can agree on the best method that wouldn't harm your wife...that would be a better solution rather than her deciding on her own and then it results to problems (Husband FGD participant, Kilifi)

In Homa Bay and Migori counties, men were pro-contraceptives as it helped to prevent early pregnancies in adolescent girls. An IDI participant explained:

It is important to tell someone about what contraceptives is because giving birth when you are not prepared is complicating your life. Some parents won't take you to school when pregnant and you cannot take care of that child. So if they are engaging in sex, they must use contraceptives (Husbands IDI participant, Migori)

Nonetheless, the findings from Homa Bay appear to suggest that most AGYW secretly use contraceptives methods, without the knowledge of their husbands/partners. The male FGD participants reported that most men are not aware that their partners use contraceptive methods since the latter do not share such information.

Mothers-in-law appeared to support use of contraceptives to space and control the number of children that one gives birth to. An FGD participant reported, *"It is also important that they space children, because life has become hard, so they should not give birth to a large number of children as we did"* They also opined that adolescent mothers can use contraceptives to avoid pregnancies and complete their studies. According to FGD participants, *"the main benefit (to the community) is that when the girl uses contraception after giving birth, she will finish her education"* However, the discussions revealed that there were still some parents who did not approve of their adolescent girls using modern contraceptives methods especially the girls who had not given birth because they believe that contraceptives methods can cause barrenness. A participant opined:



My thoughts are that young girls between the ages of 15 and 19 years should not use contraceptives like injections. These contraceptives should be used by those who have already given birth since I believe when young girls use contraceptives they might be unable to conceive. These contraceptives might cause reproductive complications (Mothers-in-law IDI, Narok)

In Homa Bay, mothers-in-law perceived contraceptives as effective methods to prevent unwanted pregnancies and girls should start using them when they are at least 15 years old. They further explained that the community welcomed use of contraceptives among adolescent girls because this reduced the case of adolescent pregnancies. This shows that the community had generally accepted use of contraceptives by the adolescent girls but there were pockets of parents and husbands/male partners who see contraceptive use as a bad thing.

### **3.3.3 Community Expectations from Binti Shupavu**

The information from girls in Narok County revealed that the program did not provide the adolescents with the means to use their skills to earn a living after training. They would like to be supported to get capital and/or the equipment they need to be able to work and earn a living as stated by an IDI participant: *"We are not getting there because most of us lack the capital...I would want the program to support me with materials for the salon so that I may earn money and also tutor others"* It emerged that awareness creation was considered an important tool in making the household decision makers to allow the girls to attend Binti Shupavu trainings. An IDI participant in Kilifi County stated, *"You know any refusal from in-laws or parents/ husband is due lack of information. I feel if they are informed, they will accept to give permission."*

In Homa Bay, an IDI participant emphasized that mentors should talk to parents first and seek permission so that the girls can be allowed to attend the program. She also suggested the need to improve the training program and increase the number of mentors. She suggested having the program on weekends from 2pm onwards and they be provided with learning materials for the courses offered. She said that *"they should provide us with materials for making mats and braiding"*. It appears there are skill programs that were started but dropped before completion as was noted by an IDI participant, *"What they should do is, for example, if a skill class is introduced like baking, they should ensure it goes to term because it made others to lose hope"*. She further suggested the need to manage time and stick to the approved training schedule.

Husbands pointed to the need to make those who complete the training champions, who will in turn mobilize and train other girls in the community. They also expect the training to be offered in local languages as most of the targeted girls are not conversant with English or Kiswahili. Other expectations that emanated from the focus discussions include organizing door-to-door training in order to reach out to all targeted girls, introduction of sports in the training program and running the program on weekends, preferably Saturdays. The aforementioned expectations surfaced in



Kilifi County as well. In addition, the husbands expressed the desire to be involved in the training sessions:

We (spouses) should be involved during seminars like attending that seminar with your wife so that you get advised together. Even for the skills (choosing skills), she may go there alone and they choose a skill for her that I would not be expecting when she comes home (Husbands FGD, Kilifi)

Other expectations by husbands included frequent seminars and barazas, road shows, use of locally drawn trainers and inclusion of men in the planned program activities. In Homa Bay, husbands argued that awareness creation to the whole community was likely to reduce spousal conflicts because they would have been made aware that the program exists. They reiterated the use of champions for mobilization of other girls and the involvement of male partners in the training program. According to an IDI participant, *"If you educate the boy too, when they meet together, they decide but if a girl knows how to use a condom and a man does not know, he will think he is being cheated on"* While an FGD participant noted, *"the non-involvement of men is like segregation. If it is only channeled to one particular gender, we risk leaving the other gender out with information"* The location of the training centers was also discussed, with male partners suggesting that the centers should be located centrally to ease accessibility for those traveling from the furthest and hard-to-reach areas in the county.

Mothers-in-law expected men to be educated about contraceptives methods. An FGD participant in Narok noted that *"men can be educated separately and women separately. When men are gathered together, they will also learn and understand"* The participants also expect the program to link the trained girls with employers or help them get capital to start their businesses. The expectations of mothers-in-law from Homa Bay and Migori counties included the provision of sanitary towels to the adolescent girls and the distribution of brochures containing sexual health education. They also agitated for enhanced community involvement in the program through use of CHVs and village elders to mobilize more girls.

### **3.3.4 Evaluation results**

#### **3.3.4.1 Relevance**

The program seems to have contributed to the improved confidence levels in the AGYW and enabled them to gain essential skills. The AGYW reported that they were taught many skills such as how to abstain, how to use contraceptives and how to take care of themselves. They also reported that the program's awareness creation sessions had resulted in enabling those who initially could not publicly talk about contraceptives to be comfortable discussing the topic. An FGD participant stated, *"It became interesting, we could even now laugh because we became comfortable."* The milestone achieved in this area may however be slowed down by the clique of parents in some counties who are opposed to exposing their daughters to modern contraceptive





methods and services. For instance, the findings show that some parents in Narok County do not freely discuss with their children about the use of modern contraceptives. They would get angry if the child discusses the topic because they see it as a sign that their children are not behaving well. So, the girls fear discussing the use of contraceptives with them or seeking their permission to use modern contraceptives.

Program relevance was also noted in the AGYW revelation that the awareness about modern contraceptive methods enabled them to make choices about the methods that suit them best. An IDI participant stated, *"Yes it (training on modern contraceptive methods) was important because there were some girls who did not like the insertion method, so they chose the contraceptive methods that suit them"*. This finding was corroborated in the feedback from various key influencers. For instance, mothers-in-law from Homa Bay reported that the AGYW who participated in the program were knowledgeable about contraceptives. A participant noted, *"My girl has learnt a lot because now she knows all types of contraceptives, signs and symptoms of certain diseases"*

In Homa Bay, mothers-in-law perceived contraceptives as effective methods to prevent unwanted pregnancies and supported the idea of AGYW using them when they are at least 15 years old. They affirmed that the community welcomes use of contraceptives among adolescent girls because their use reduces incidences of adolescent pregnancies. This shows that the community has generally accepted the use of contraceptives by the AGYW save for a few parents who see contraceptive use as a terrible thing. It demonstrates the program's relevance of having key influencers who are closest to the AGYW, support them to make choices about their bodies and futures such as contraceptive use.

#### **3.3.4.2 Effectiveness**

The achievement of the program's goal of creating awareness about contraceptives among the AGYW was evident on the ground although there appeared to be some bottlenecks to the realization of this goal in some counties. For instance, while most of the AGYW confirmed that they were aware that modern contraceptive services are available for free in all clinics, the focus discussion with men in Narok and Kilifi revealed a low level of awareness about modern contraceptive methods in the community. This is likely to create room for low support of the program's objectives by the community.

As a result of the awareness about modern contraceptive methods and services, there was a reduction in transactional sex among AGYW as they could now courageously ask their parents to provide for them the basic need and the parents too understood they needed to provide for their girls. This change was expressed by most of the AGYW across the four counties. For instance, one girl narrated:



Some of us used to be lured by a motor rider who provides for you pads and essentials, but through Binti Shupavu you can face your parents every end month remind them of those essentials, and they also now know they need to provide (AGYW IDI participant, Narok)

According to the health providers, CHVs and peer educators, the program was effective in improving the uptake of modern contraceptive methods in the four counties. In Narok, for example, a participant reported:

When you look at that graph, it is rising. When we started the first meeting, I remember we didn't get even one to get the contraceptive. They all refused so we continued pursuing them with more education and trainings. So after two to three months, they started coming on their own and some with their mothers. In short, recently the uptake has shot up (Peer educator, Narok)

However, regional disparities were reported in the level of uptake with urban areas recording a higher uptake than did the rural areas, a trend that was attributed to the favorable exposure to information about reproductive health among urban dwellers. An RH focal person reported:

... when you go to the urban areas, because of the way the information is available to the parents and guardians, you will get of course there is a 50-50 win to contraceptives, as compared with a rural area where there is a knowledge gap among the community about contraceptives (RH Focal Person, Kilifi)

A CHV reported that the program has "had little impact on the girls because it focuses only on the selected girls and the implementers do not penetrate into the community to sensitize all girls within that age group." The program also did not reach places where young women are found especially along the beaches and at schools. It also missed educating the men who mingle with the young girls. A key informant from Migori County affirmed that men are usually left out in family planning discussions taking place in the community.

As noted in the foregoing section, misinformation about the benefits and side effects of modern contraceptives remains a major challenge in the acceptance and adoption of contraception in the community. For instance, the most used modern contraceptive methods across the four counties were injectables, implants and pills, with participants saying that women preferred injectables since they are reversible. The finding is comparable to the recently released report of the Kenya Demographic and Health Survey which showed that the most used methods are injectables, implants, and contraceptive pills in that order (KNBS, 2020). The low to average uptake of contraceptive methods was attributed to the short duration of the Binti Shupavu program in Kilifi County. Although the uptake of modern contraceptive methods was reported to have increased and adolescent girls were now allowed to use them in Migori and Homa Bay counties, men disliked





long term methods because of the fear that they may cause infertility. They also cited religious influence and low awareness as the major hindrances to the uptake of contraceptive methods:

The level of use of contraceptives is around 50 percent because we still have issues of religion and lack information on how to use condoms – because if a condom can burst why should they use it. Then for religion they (Islamic, Legio Maria and Catholic) argue that the bible says, ‘go and fill the earth’, so why should they not do so (Husband IDI participant, Migori)

### 3.3.4.3 Efficiency

A number of issues were raised with regards to how efficiently the program is being implemented. For instance, in Kilifi County, some of the adolescent girls expressed disappointment about the program’s failure to conduct the hoped-for skills training. An IDI participant said, "*The challenge that I had was interest in baking cake but that program did not go forth and I did not bake.*" Similarly, they expressed dissatisfaction with the lack of close follow-ups for those who had been trained about contraceptives. An IDI participant lamented:

At some point we saw that we had attended a lot of meetings but there weren’t people (doctors) coming to check on us. We are always by ourselves every day...we were being told that they (doctors) might come the following week but when that week comes, they are nowhere to be found (AGYW IDI participant, Narok.)

The findings also revealed that there were skill programs that were started but dropped before completion as was noted by an IDI participant, "*What they should do is, for example, if a skill class is introduced like baking, they should ensure it goes to term because it makes others lose hope*". She further suggested the need to manage time and stick to the approved training schedule, further signaling some elements of inefficiency.

The findings revealed that more meetings and close follow-ups after training would have accrued more benefits to the AGYW. For instance, mothers-in-law reported that the program held a few meetings with the girls but stopped abruptly in Narok County. According to an FGD participant:

It was the girls that were being taught about contraception...They were mostly targeting the young mothers who gave birth, and they didn't go back to school... We felt like that program would have been of help, but those people involved didn't come back to the community, because I would have received a call (Mother in-laws FGD, participant, Narok)

The low uptake of modern contraceptive methods reported elsewhere in this report could also be as a result of the limited use of a variety to channel information to the community. The findings show that communication on modern contraceptives was mainly undertaken by CHVs and village



elders. Indeed, mothers-in-law affirmed that CHVs usually went house to house giving information about modern contraceptive and referring the girls to health facilities while village elders informed the community members about modern contraceptives. While IPCs are effective channels of communication, their success can be enhanced by directing some resources to mass media and digital communication channels for an impactful and wider reach.

According to the Kilifi Focal Person some of the gaps in the program include stock-outs at the health facility, lack of information among the adolescents, a lack of information among parents and religious leaders. The same gaps were mentioned in Migori County. Furthermore, accessibility to information especially for those in rural set-up from low-income households that don't own radios or smartphones was not factored in the program's implementation plan.

The participants suggested adequate facilitation of those involved in creating awareness about modern contraceptive methods in the communities so that they can reach everyone. According to a key informant from Migori, “*sometimes the facilitation becomes an issue, and you are not able to reach all those adolescents we intend to reach during that period of time we intend to reach*” The community sensitization drives should also involve everyone including healthcare workers, community leaders and religious leaders for greater impact to be achieved. Community outreach was proposed for reaching those who may not make it to the facilities because of long distances and lack of fare to the facilities. A key influencer reported:

... the facilities within their (adolescent girls) reach are few. These are people whom you have to go where they are for them to get the services. So sometimes it is not always possible for them to travel to the facilities to get these services, unless you move out wherever they live. That is the only way they can access the services (KII participant, Migori County).

Also notable from the findings is the inadequate personnel trained in offering youth-friendly services (YFS) that support the program's implementation. This was raised by a Sub- County Coordinator who stated that most of the staff are not YFS trained to offer youth-friendly services.

#### **3.3.4.4 Impact**

The impact of the Binti Shupavu program was evaluated at individual and community levels. At individual level, the evaluation sought to establish the intended and unintended outcomes of the program on the AGYW enrolled in the program. At the community level, the evaluation focused on the intended and unintended effects of the program to the wider community.

##### ***Impact to the life of the girl child***

Some of the impacts of the program on the AGYW are enabling the girls to access modern contraceptive methods and equip them with skills which they can use to earn a living. The findings



indicate that the program has had a positive impact in creating awareness to and improving access to contraceptive services among most adolescent girls. A participant reported:

I was among those girls who attended the sessions, even girls from secondary schools were invited to attend the sessions. The discussion was mainly about contraception, and there were girls who mentioned that they were using contraception. The rest of the girls were asked if they wanted to use contraception, and the majority said they wanted to. (AGYW FGD participant, Narok)

The impact of the program on making AGYW, especially the emancipated minors, to be aware of and access modern contraceptive methods was also noted in the interviews and discussions with the AGYW. One of them explained:

...at the beginning we had a problem with contraceptives. Being underage, you would not receive the services – we were at risk... The program implementers have provided us with contraceptives and created good relationship between nurses and clients because previously we were denied the services, but we are being provided very well (AGYW IDI participant, Homa Bay)

The husbands/partners to the AGYW equally opined that the program had increased uptake of modern contraceptive methods. One FGD participant in Kilifi explained, *"during that time (the training period) is when you will find most of them (girls) taking contraceptives so that they concentrate – they get ample time to practice those skills"*. They mentioned that girls who go through the Binti Shupavu training behave well. One of the participants noted, *"you will see a change of behaviour in those girls who attend such meetings. They follow the right things while the others are still wayward"*

As relates to skills acquisition, the AGYW reported that they felt empowered and were better positioned to provide for their families. An IDI participant reported:

All I can say is empower. For someone like me, before I got into the program, I was desperate after being married and having a child. But after learning the skills, there is something that I can provide to my family...Previously I had nothing, but through skills learnt, I can braid hair the 'rasta' style and get paid even sh. 300 which I can use to buy something for myself. We prepare soap, sell it and later save the money. We were also taught on budgeting and now I have good savings that I can plan for (AGYW IDI, Homa Bay)

Still on empowerment, mothers-in-law in Narok County reported that the AGYW knew how to protect themselves from unwanted pregnancies and had acquired skills to use in generating income. A mothers-in-law IDI participant explained, *"The adolescent girls were taught how to support themselves financially. In addition, how to protect themselves against early teenage pregnancy through sexual and reproductive health. Binti Shupavu has really helped the girls"* The



reduction of pregnancy cases among adolescents, particularly the school going ones, was also mentioned by the AGYW's husbands/partners in Narok County.

The acquisition of soft and entrepreneurial skills such as goal setting were mentioned by mother-in-laws in Kilifi County. They observed that adolescent girls, especially those who had given birth and lost hope got a chance to realize their goals in life. One participant noted, *"the other day I saw these girls showcasing the soft skills they had acquired during their training like soap making and they plaited each other as we witnessed. This was something commendable."* Similarly, an RH focal person reported, *"Currently the girls with the soft skills are able to sell the jik, to sell the soap they are making at a fee to maintain themselves and probably for their young ones."*

The program has also enabled AGYW to focus on achieving their goals as well as develop confidence in discussing matters about contraceptives. For instance, in Homa Bay County, the AGYWs reported that they were now "courageous and comfortable" discussing issues around contraceptives. An IDI participant articulated, *"When they came to talk about contraceptives, I became comfortable and no longer embarrassed to hear a word like condom being talked about publicly"* A peer educator in Kilifi expressed that adolescent girls can go to school and pursue their dreams because contraceptives help them to prevent unwanted pregnancies that can interfere with their education.

### ***Impact of Binti Shupavu to the community***

The community also had its share of benefits arising from the Binti Shupavu program interventions. For instance, in Homa Bay, the girls participating in the focus discussion reported that incidences of early/ unwanted pregnancies had drastically reduced due to the Binti Shupavu teachings. Likewise, men in Homa Bay and Migori counties reported to be pro-contraceptives, arguing that it helped to prevent early pregnancies in adolescent girls. An IDI participant explained:

It is important to tell someone about what family planning is because giving birth when you are not prepared is complicating your life. Some parents will not take you to school when pregnant and you cannot take care of that child. So, if they are engaging in sex, they must use contraceptives (Husbands IDI participant, Migori)

Indeed, the findings revealed that there are a few men who support the use of modern contraceptives to space children, and they even initiate discussions about using contraceptives. A husband in an IDI affirmed, *"I discussed it with her (my spouse) until we came to a decision that we should use this method of family planning...In fact, I was the one who initiated it"* This support for using contraceptive methods notwithstanding, men still were hesitant to accompany their wives to the clinic because they feel it is embarrassing. An IDI participant emphatically said: *"Men find it hard to accompany their partners. Let the woman go on her own...It looks embarrassing. I do*



*not know the reason. There is this notion that a woman should walk on her own”*

This was reiterated in the FGD where a participant explained that *"To a larger extent, a man accompanying his wife to the health facility will be ridiculed by other members of the community. He will not be considered a total man."* The increased uptake of modern contraceptive methods among adolescents suggests that more parents understand the benefits of modern contraceptives and allow their daughters to seek modern contraceptive services. A health provider narrated, *"If you look at our register now you will see an increase meaning that parents are now allowing their daughters to come for the contraceptive services meaning they have seen the importance."*

The awareness creation and uptake of modern contraceptives also had a bearing on schooling and education in the community. As reported by the mothers-in-law from Narok County, most of the girls who had dropped out of school decided to go back to school and complete their education. A peer educator reported:

The major impact is that parents are calm nowadays. Before, they were even crying about their girls getting pregnant but nowadays the mothers and their daughters get along well because they know the importance of going to school... When a girl got pregnant, they would go back home but nowadays she is put on a family planning method, she nurses her baby and after some few months she goes back to school (Peer Educator, Narok)

That said, the findings revealed that there still exist stereotypes about modern contraceptive use. According to a CHV in Homa Bay, those who don't know much about contraceptives view young women who use contraceptives as women who love sex escapades and not as those who are aware about the importance of using modern contraceptives. According to the CHV, *"it will be taken that the daughter of so and so loves sex and cannot sustain herself without it"*

#### **3.3.4.5 Sustainability**

The findings revealed that the modern contraceptive services are accessed at a fee in some public health facilities. For instance, in Narok County, a mother-in-law complained that *"... when I took my two daughters for contraception, we paid money. We were told that the government supplied the contraception to hospitals to be offered to the public for free, but the health providers are selling them to us..."*. In Kilifi, the mothers-in-law explained that the requirement that women should undergo a pregnancy test before getting a contraceptive method was a challenge especially when they did not have money to pay for the test. A participant reported:

You find that a CHV may recommend to a woman a contraceptive method. The woman is required to go through some testing like urine to test for pregnancy. To evade the tests, some would lie that they are in their periods, but this was discovered. So, whether on periods or not, you have to be tested, which requires money (sh. 100). This woman may not be able to get the service because of financial constraints. She may end up going home without getting the service and



that is how some get unplanned pregnancies (Mothers-in-law IDI participant, Kilifi)

The information from participants in Narok County revealed that the program does not provide the adolescents with the means to use their skills to earn a living after training them. They would like to be supported to get capital and/or the equipment they need to be able to work and earn a living as stated by an IDI participant: *“We are not getting there because most of them lack the capital...I would want the program to support me with materials for the salon so that I may earn money and also tutor others”* It is worth noting that most of the girls come from impoverished and economically disadvantaged families that may not readily afford to pay for modern contraceptive services or start income generating activities without financial support. This consequently implies that they are likely to involuntarily discontinue accessing the services due to inability to pay in the future.

Other potential threats to the continuity of AGYW using modern contraceptive services in the targeted counties, and particularly in Narok County, include poor nutrition, long distances covered, and heavy chores as voiced by a participant:

The community has accepted the use of contraception because it is not doing them any harm. Everyone is using contraception. We even travel to far places to get it, others buy them. The only problem is that some people do not get enough food, and using contraception requires that you eat well (Mothers in-law FGD participant, Narok)

From a community perspective, there is limited goodwill to support the program beyond its life. This includes the willingness of mothers-in-law to mobilize their adolescent girls to be taught about contraceptives if they (mothers-in-law) are trained. A participant explained:

We can start by gathering the girls together, and there is no girl who does not listen to their mother and talk to them about what we have been trained in. Respect is very important to push things forward...When you guide the girls you can protect them from getting pregnant. It is important to advise the girls on how to be respectful (Mothers-in-law FGD participant, Narok).

The program would be more sustainable if support from varied stakeholders/influencers, and not from mothers-in-law alone, was achieved. On the contrary, some of the would-be key influencers were reported to be the very people discouraging adolescent girls from using modern contraceptives. Key influencers expressed frustration from the teachers who they claimed discourage young girls to not use modern contraceptive methods. For instance, in Migori, a health provider said, *“If Binti Shupavu can allow us to meet the teachers it will be good... The main barriers now are the teachers. Children are willing but they fear if they use them, they will be punished in school.”*





Further, husbands pointed out the need to make those who complete the training champions mobilize and train other girls in the community. They also suggested that the training should be offered in local languages as most of the targeted girls are not conversant with English or Kiswahili. This could expand the reach of the program in the community.





#### **Chapter 4: Discussion and Conclusions**

This baseline survey was conducted to uncover useful insights that would facilitate the A360 project in Kenya to make course corrections to optimize the implementation and to make adaptations to the intervention to increase the potential for detectable impact at the endline survey. This endline survey is planned to be executed 18 months after the baseline. The survey has established that the population of adolescent girls living within the catchment of implementation facilities is ideal for the intervention. A substantial population of girls in the implementation areas are married or are teen mothers and many are sexually active, implying that they are rightful candidates for sexual and reproductive health interventions. Fortunately, many girls have heard about contraceptives and a substantial proportion know most of the methods and their benefits. This lays a good foundation upon which the Binti Shupavu intervention can operate so that the relevance of contraceptives can be amplified and the ambivalence to using contraceptives can be reduced.

The survey has established that the self-reported confidence among girls to access, discuss their needs with their partners or husbands and with providers and to use contraceptives is high. Although data from self-reports are amenable to social desirability bias, the higher confidence means that less efforts are needed to convert the contraceptive intentions to actions. Binti Shupavu should strive to ensure that the aspirational program components are purposely implemented to reach as many girls as possible, as that might be a hook to shifting the tide. Furthermore, messaging should be attuned to address the common myths and misconceptions, which stand on the way for adolescents who want to use a method and are afraid of dealing with the negative consequences. The current contraceptive prevalence rates among adolescents 15-19 is more than 20 percentage points below the benchmark from the demographic health survey of 2022. This means that many girls who need to avoid or delay getting pregnant are still amenable to unintended or mistimed pregnancies. Most users are preferring to use the injectable or implants. Although these are reliable methods, sexual episodes are less frequent, and many girls might be struggling to find methods that can align with their sexual patterns for various reasons including being unaware of these alternatives and lack of consistent access. Ensuring that the full menu of contraceptives is readily and consistently available at sites where the Binti Shupavu intervention is implemented and messaging by providers that positions short-term method use as part of the array will go along in ensuring the needs and preferences of all adolescent girls are catered for. Working with government stakeholders and other implementing partners could also ensure that commodity outages are reduced. Furthermore, messaging that emphasizes use in line with the girls' sexual patterns and use for effective pregnancy prevention rather than contiguous uninterrupted use (even when not in need) will likely motivate sustained use and result to measurable impact at the endline survey.

The survey has established that there are obstructive norms around contraceptive use in the vicinity when Binti Shupavu is implemented. Many girls disapprove of the use of contraceptives by



unmarried adolescents and by couples in which one party is an adolescent girl.

This consequently fuels covert contraceptive use among adolescents. Additionally, many girls are unable to engage their male partners and husbands in decision making because of these descriptive norms and therefore do not enjoy the benefits of collective decision making. Purposefully expanding opportunities to engage potential and real male partners to adolescent girls could aid to emphasize their roles, educate them on the relevance of contraceptives and increase the support they could provide to adolescent girls. Other key influencers would also require a deliberate involvement, so that their willingness to support adolescents and advocate for the provision of comprehensive sexual and reproductive health services is increased.

This survey has identified that Binti Shupavu is gaining broader acceptability in the areas where it is implemented. In under one year of implementation, the program is known to over one third of girls in the catchment areas. The key influencers to Binti Shupavu see value and are increasingly acceptable to what the intervention seeks to attain. There is still a lot that needs to be done, so that these communities are saturated with Binti Shupavu messages and that many more girls participate in the intervention activities. There are good signals that being exposed to Binti Shupavu is a predictor of good outcomes along the pathway to sustained contraceptive use. A total market approach blending above and below the line communication channels is needed to increase exposure and magnify the role of exposure towards its contribution to the attainment of the projected intervention outcomes. Finally, substantial access to mobile telephone and internet services, including social media platforms, was established. A360 Kenya should identify ways to tap into the increasing mobile and internet penetration to make it a useful tool in relaying demand creation messages and for receiving feedback on how the intervention is implemented.

Based on the foregoing discussion, study makes the following conclusions:

1. There is deliberate intention and willingness among the girls to delay pregnancy. However, the low perceived HIV risk among the majority sexually active girls may thwart the efforts of reducing HIV infections in these HIV-prone areas.
2. A majority of the adolescent girls have a comprehensive knowledge of modern contraceptive methods especially the injectable, implants, male condoms and pills. This comprehensive knowledge is attributable to the county of residence, exposure to Binti Shupavu, being sexually active and having a higher perceived social support and agency scores.
3. Adolescent girls perceive contraceptives to be relevant in assisting them to achieve their goals, complete education and pursue a better life. They are more likely to see the relevance of contraceptives if they come from deprived households, are sexually active, have comprehensive contraceptive knowledge, perceive themselves to have less control from the husband/male partner or relatives in making reproductive health decisions and have perceived support from significant others.
4. The implant, male condom and injectable are the predominant contraceptive methods used by adolescent girls. However, the use of contraceptives was still low among the sexually-active



girls. There is evidence of unmet need among adolescent girls as a majority of non-users expressed willingness to use a contraceptive in the future. The study further concludes that current contraceptive use is predicted by being an ever married adolescent girl, having at least one child, having comprehensive contraceptive knowledge, having more frequent sex, perceiving that contraceptives are relevant for adolescent girls and exposure to Binti Shupavu.

5. Exposure to Binti Shupavu, county of residency, completion of primary or secondary level of education, comprehensive contraceptive knowledge and perceived relevance of contraceptives have a positive effect on the contraceptive self-efficacy of the adolescent girls.
6. There is a low exposure to Binti Shupavu among the girls and posters, health facilities, peers or CHVs were the main media of exposure. The exposure was higher for Migori and Kilifi counties and the girls' participation was higher in Binti shupavu clinics, stories and classes. Exposure to Binti Shupavu was associated with comprehensive contraceptive knowledge, a higher perceived contraceptive self-efficacy, non-Catholic religious affiliation, emancipated girls under 18 years and having had sex more than a year before the survey.
7. There is general key influencer acceptance of contraceptive use among girls in the community. The major misconceptions that affect uptake of contraceptives are the perceived side effects of contraceptives.
8. There is limited awareness of Binti Shupavu and consequently non-involvement of key influencers especially the husbands/partners and mothers-in-law to the girls.
9. Parental and spousal/partner disapproval of adolescent girls using modern contraceptives is a dominant challenge to contraceptive use in the four counties.



## Chapter 5: Recommendations

The following are the key recommendations to the Binti Shupavu implementers.

1. Implement targeted demand creation by ensuring that mobilizers of adolescent girls to attend program activities can profile population segments that have a need for contraceptives.
2. Invest in harvesting lessons of what is working in relatively well performing counties and apply these lessons to the other counties.
3. Employ blended approaches (interpersonal and alternative channels) to reach the various segments of the adolescent girls.
4. Scale the participation of girls in the intervention activities to increasing program effectiveness in reaching more girls with all the components of the intervention.
5. Strengthen the aspirational components of Binti Shupavu so as to awaken girls to identify their life goals and position contraceptives as a vital ingredient for them to achieve these goals. This will increase the relevance of contraceptives to girls even when they might have no immediate need and prepare them adequately since they would be in need in the future.
6. Strengthen the intervention components that influence the attitudes, knowledge and perspectives of the key influencers. From the two data sources for this survey, there is consensus that not all stakeholders are agreeable to contraceptive use among adolescent girls and that some stakeholders wield substantial influence on the decisions girls make.
7. Collaborate with government stakeholders to ensure continuous supply of contraceptive commodities since girls do express a need to access the full array of methods.



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## Annexes

### Annex 1: Sample distribution for the population-based survey

County	Target Population	County sample size		Sub-county sample size		
		AGYW	Villages/ CHUs	No. of sub- counties	AGYW per sub-county	Villages/CHUs per sub-county
Migori	56,144	423	42	4	106	11
Homa Bay	40,941	309	31	4	77	8
Kilifi	19,377	146	15	4	37	4
Narok	14,755	111	11	4	29	3
<b>Total</b>	<b>131,217</b>	<b>989</b>	<b>99</b>	<b>16</b>		





## Annex 2: Distribution of sampled facilities and CHUs

County	Sub-county	No. of facilities	No. of CHUs
Migori	Kuria East	10	10
	Kuria West	11	11
	Suna East	2	2
	Suna West*	7	7
	Uriri	12	12
	<b>Total</b>	<b>42</b>	<b>42</b>
Homa Bay	Homa Bay Town	9	9
	Mbita	10	10
	Karachuonyo	2	2
	Suba South	5	5
	Ndhiwa*	5	5
	<b>Total</b>	<b>31</b>	<b>31</b>
Kilifi	Kaloleni	4	4
	Kilifi North	3	3
	Magarini	4	4
	Malindi	4	4
	<b>Total</b>	<b>15</b>	<b>15</b>
Narok	Narok North	3	3
	Narok South	3	3
	Narok West	3	3
	Transmara East	3	3
	<b>Total</b>	<b>12</b>	<b>12</b>



### Annex 3: Distribution of the FGDs, KIIs and IDIs

County	FGDs	IDIs	KIIs
Homa Bay	2	3	8
Migori	1	2	7
Narok	3	3	8
Kilifi	2	2	7
<b>Total</b>	8	10	30



#### Annex 4: Perceived self-efficacy

	<b>Strongly Agree (%)</b>	<b>Agree (%)</b>	<b>Neither agree nor disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
It is easy for me to discuss the use of method to avoid, delay or spacing a pregnancy with my husband/husband.	44.8	32.3	5.9	10.2	6.8
It is easy for me to discuss the use of method to avoid or delay or spacing a pregnancy with my friends	38.7	32.6	4.1	13.1	11.5
I am not ashamed to ask for a method to avoid, delay or spacing a pregnancy from health facilities/pharmacies.	37.6	35.5	4.2	13.0	9.6
I am able to use a method to avoid, delay or spacing a pregnancy correctly and according to the instructions.	40.5	39.8	7.3	7.2	5.1
I am able to remember to get/use a method to avoid, delay or spacing a pregnancy on schedule	38.6	38.0	8.5	9.6	5.4
I can choose the appropriate method to avoid, delay or spacing a pregnancy method for me	38.8	41.2	5.8	9.8	4.4
I can seek advice about method to avoid, delay or spacing a pregnancy methods	44.9	40.7	5.1	5.9	3.4
I am capable of using a method to space my births and chose when and how many children to have	42.9	42.0	5.5	6.0	3.6
I can convince my husband to use a method to avoid, delay or spacing a pregnancy	37.7	36.8	8.5	10.5	6.4
I have goals for my life	62.4	32.6	2.1	2.6	0.4
I believe I have some tools to help me achieve my goals for my life	43.8	39.7	7.4	7.2	1.8
I have little control over the things that happen to me	21.0	43.0	11.7	15.9	8.4
I believe preventing unintended pregnancy is important to help me achieve my goals for life	59.6	33.9	2.0	3.4	1.1



**Annex 5: Perceived locus of control**

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither agree nor disagree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
My husband/partner decides if we will use a method to avoid or delay pregnancy or not.	17.2	30.3	12.8	21.4	18.3
I cannot use a method to avoid or delay pregnancy without my husband/partner's permission	23.8	34.1	8.3	18.8	15.0
My husband/partner decides or shall decide how many children I should have	18.1	29.7	16.0	20.0	16.2
My mother-in-law decides or shall decide how many children I should have	2.7	8.1	2.9	23.3	63.1
My parents decide or shall decide how many children I should have	2.9	10.0	2.0	26.6	58.5
It is up to the creator to decide how many children I should have	42.2	31.5	6.2	7.8	12.3



### Annex 6: Perceived social support and agency

	<b>Not at all/a little true</b>	<b>Moderately true</b>	<b>Very true</b>
I have a someone close who would help me with my problems and troubles if I needed	11.4	24.2	64.4
I have a someone close who accepts me as I am.	8.1	27.1	64.8
I have a someone close who trusts me to make the right decisions.	10.5	27.7	61.7
I have a someone close who can help me to achieve my goals in life	12.6	27.4	60.0
I can imagine what my future will be like.	15.7	28.9	55.4
I have an idea what I can do to eventually reach my goals.	13.5	30.1	56.4
My sexual needs or desires are important	32.6	27.3	40.1
I think it would be important to focus on my own pleasure as well as my husband's when having sex	35.3	24.5	40.2
I expect to enjoy sex every time I think about it	47.8	25.7	26.5



**Annex 7: Common descriptive norms around contraceptives**

<b>Descriptive norm</b>	<b>Most of them</b>	<b>Less than half</b>	<b>None</b>	<b>Don't know</b>
How many married girls (or girls living as married) aged 15-19 years in your community do you believe discuss using a method to avoid, delay or spacing a pregnancy with their husband/partner?	286 (29.6%)	216 (22.3%)	272 (28.1%)	193 (20.0%)
How many married girls(or living as married) aged 15-19 years in your community do you believe use a method to avoid, delay or spacing a pregnancy?	333 (34.4%)	191 (19.8%)	264 (27.3%)	179 (18.5%)
How many married girls (or living as married) aged 15-19 years in your community do you believe use a method to avoid, delay or spacing a pregnancy in secrecy from their husband/partner?	295 (30.5%)	178 (18.4%)	274 (28.3%)	220 (22.8%)
	Approve	Neither approve nor disapprove	Disapprove	Don't Know
Do you approve or disapprove that adolescent girls should use contraceptive method to avoid or delay pregnancy?	633 (65.5%)	85 (8.8%)	243 (25.1%)	6 (0.6%)
Do you approve or disapprove of couples who are not married using contraceptive to avoid or delay pregnancy?	658 (68.0%)	61 (6.3%)	241 (24.9%)	7 (0.7%)



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