A Report of Accelerate Outcome 3 Program Indicators in 13 Kenyan Counties.

Findings from Exit Interviews (January- December 2022)

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Acknowledgment

This report was prepared by Population Services International (PSI). The work was led by Julius Njogu, (Evidence and Learning Advisor, email: jnjogu@psi.org) under technical leadership of Dr. Claire Rothschild (Senior Technical Advisor, SRH Strategic Evidence & Learning).

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1.0 Introduction

1.1 Background Information

In Kenya, the burden of GBV is high, 2014 Kenya Demographic Survey showed, nearly half (45%) of women of reproductive age (WRA) reported at least one lifetime experience of violence, including 20% and 8% who experienced acts of physical violence and sexual violence in the past 12 months, respectively (KNBS, 2014). Evidence shows, most acts of violence among WRA occur at home by intimate partners (IPV), and worryingly one in four men (36%) and women (42%) in the country endorse a culture of wife beating (KNBS, 2014). **Furthermore, a fifth (21%) of WRA in Kenya are living with harmful effects of FGM/C, albeit, dominantly practised among specific ethnic populations,** including, Mbeere, Pokot, Maasai, Kisii/Kuria, Samburu, Rendille, Gabbra, Somali, and Borana (71%-100%). Among these communities, women circumcision is largely practised as a way of preparing girls for marriage and social acceptance, while the practice is commonly characterized with misconceptions including beliefs of cleanliness/hygiene, preserving virginity and religious obligation.

Evidence shows millions of Kenyan girls are particularly vulnerable to early teenage pregnancy and motherhood, often associated with risky sexual behaviours and early child marriages. According to recent national estimates, approximately a third or 37% of Kenyan girls are married off at exact age of 18 years or below, including 8% who are married by exact age of 15 (KNBS, 2014). Furthermore, body of knowledge suggest wide variations exist in the performance of SRH indicators, given some counties perform unfavourably in comparison to the national estimates. For instance, in 2014, among women aged 20-49, the national median age at first sexual intercourse was 18 years, compared with less than 16 in Homabay and Samburu, less than 17 in Kwale and Narok, and was less than 18 in West Pokot, Marsabit, Elgeyo Marakwet and Baringo. While the national estimate for teenage pregnancy/motherhood was 18%, this was as high as 40% in Narok, 33% in Homabay; 20-26% in Kajiado, West Pokot, Kilifi and Kwale (KNBS, 2014).

Although Kenya has made great strides toward increased uptake of family planning, including recently exceeded FP2020 target of 58% modern contraceptive use by married women (FP2020, no date), many women still have unmet need for contraception and disaggregated data by region show wide disparity with very low use in some of the regions/counties. Specifically, by 2014, almost a fifth (18%) of currently married women expressed unmet need for family planning services, including 9% in need of spacing and 8% in need of limiting (KNBS, 2014). Some counties reported very low use of modern contraception among married women, which was nearly five times less than the national estimate, including 2-6% in Mandera and Garissa, 11-13% in Marsabit and West Pokot, was also low in Samburu (20%), Baringo, Kilifi, Kwale and Narok (33-38%), and ranged between 44% in Elgeyo Marakwet and 54% in Nairobi (KNBS, 2014). Furthermore, while the national estimate shows nearly universal awareness of any method of family planning among married WRA (99%), only half of married women (50%) in Mandera were knowledgeable, 76% in West Pokot, and 87% in Garissa (KNBS, 2014).

Documented literature shows, multiple barriers hinder uptake of family planning services such as low awareness of FP methods (e.g., 50% among WRA in Mandera), religious and sociocultural factors including misconception and myths, and lack of spousal support. Furthermore, woman's decision to adopt a method or to continue using a method or even to switch method is influenced by multiple health system factors including continuous availability of contraceptive commodities; availability of a trained provider/equipment; sufficient counselling including all four pieces of information as defined by the method information index plus (MII+); provider bias and other negative behaviours, previous experiences at the service delivery point (SDP) including privacy, confidentiality and respect, out-of-pocket cost, distance to the SDP, among other reasons (PMA 2020a, 2020b; PS Kenya, 2020).

1.2 *Accelerate* program

Population Services Kenya (PS Kenya) led consortium in partnership with Gender Based Violence and Recovery Centre (GVRC), and Population Services International (PSI) is implementing a five-year (2021-2025) Accelerate project funded by Danish government. Accelerate project is designed to contribute toward ICPD25 promises of zero unmet need for contraception, zero preventable maternal deaths and zero gender-based violence and harmful practices. Accelerate seeks to build on the milestones that Kenya has achieved towards the realization of true universal access to quality sexual and reproductive health services, prevention, and management of gender-based violence and reduction in harmful traditional practices. Accelerate is focused on 13 underserved, and hard-to-reach counties of West Pokot, Elgeyo Marakwet, Baringo, Narok, Kajiado, Samburu, Garissa, Mandera, Marsabit, Homabay, Kilifi, Kwale and Nairobi.

Among the *Accelerate* implementation activities are, strategies targeting adolescent /youth (girls) so that they have an opportunity to plan their lives without the risk of unplanned pregnancies, GBV and HTPs that infringe on their rights and dignity; strategies for reaching out to survivors of GBV (women, girls, and boys) to increase their awareness and remove physical, socio-cultural, and economic barriers to reporting abuse and accessing services; strategies that target across all groups of boys, men, girls, and women to shape their attitudes towards gender equality and to play a bigger role in protecting women and girls' rights; finally deliberate strategies reaching out to marginalized women and girls such as women of low socio-economic status, those living in hard-to-reach areas (including rural), marginalized groups (including LGBTQ+ & PWD) as they are often left behind in many SRHR and GBV programs.

1.3 Research Significance

Many Kenyan communities have deep seated traditions, sometimes intertwined with religious beliefs which tolerate, endorse, and normalize GBV, particularly emboldening practices of IPV, FGM/C, child marriage. Interventions such as social and behavior change communication (SBCC) strategies play a significant role in reaching communities with powerful messages that persuade abandonment of harmful traditions and promotion of increased respect for women and girls' rights, including autonomy in sexual and reproductive health. Monitoring the knowledge and perception of human rights, GBV and SRHR therefore forms an integral informational component for assessing these indicators among the reached population. Contemporary data from this study provides timely evidence for appropriate program adaptation, including redesigning of SBCC strategies.

1.4 Research Questions

The research sought to answer the following nine questions, among populations directly reached by the Accelerate social and behaviour change communication (SBCC) intervention through the channel of community dialogue.

1. What is the proportion of individuals who know any of the legal rights of women?
2. What is the proportion of women and girls who demonstrate knowledge of social welfare services available for GBV survivors?
3. What is the proportion of people who do not intend to have any of their daughters undergo FGM/C?
4. What is the proportion of individuals who believe child marriage should be stopped?
5. What is the proportion of individuals who say that wife beating is an acceptable way for husbands to discipline their wives?
6. What is the proportion of individuals who would assist a woman being beaten by her husband or partner?
7. What is the proportion of individuals who agree that a woman has a right to refuse sex?
8. What is the proportion of girls that feel able to say no to sexual activity?
9. What is the proportion of adolescents (girls & boys) directly reached by the program who are confident that they could get their partner(s) to use contraceptives or condoms if they desired?

2.0 Methods

2.1 Study Area

The study was implemented in all 13 Accelerate program counties in Kenya, namely, West Pokot, Elgeyo Marakwet, Baringo, Narok, Kajiado, Samburu, Garissa, Mandera, Marsabit, Homabay, Kilifi, Kwale and Nairobi. For purposes of delivering Accelerate interventions, these counties are organized into 5 programmatic clusters which were adopted for data collection, as indicated in Table 1 below. However, given wide variations in social cultural norms within the South-west cluster, recategorization was considered. Thus, South-west domain was further divided into 3 smaller research domains consisting of Southwest A (Kajiado and Narok, both counties are mainly rural and are dominated by Maasai culture), Southwest B (Nairobi, largest urban area in Kenya with blended culture) and Southwest C (Homabay, a rural county by the shores of Lake Victoria dominated by Luo culture), while there was no further split for Coastal, Upper Eastern and North-eastern clusters. Therefore, research was implemented across 7 domains.

Table 1: Accelerate Counties and their respective research clusters.

Research cluster	Counties
South-west A	Kajiado, Narok
South-west B	Nairobi
South-west C	Homabay
North Rift	West Pokot, Elgeyo Marakwet and Baringo
Coastal	Kwale and Kilifi
Upper Eastern	Marsabit and Samburu
North-eastern	Mandera and Garissa

2.2 Study design

A cross-sectional study design was employed to collect snap-shot information from the target population of men, women, and adolescents (boys and girls) as they exited from *Accelerate* CBO facilitated community dialogue meeting. All research activities were reviewed and approved by PSI's REB through the high-risk program research ethical review function.

2.3 Study population

Study target population included population reached by *Accelerate* SBCC messaging on human rights, SRH and GBV including men, women, and adolescents. Several strategies are employed for reaching different audiences with SBCC messages including channels of mass media, posters, dialogue meetings with organized local groups as facilitated by trained CBO officers and interpersonal communication at household level using community health volunteers (CHVs). However, the study population was restricted to individuals who participated in the dialogue meetings given these events are purposefully designed to provide powerful and repeated information delivered through a facilitated community participatory dialogue meeting. The program envisaged to reach each defined group of participants[1] repeatedly with integrated SBCC messages on human rights, SRH and GBV for a minimum of three-facilitated sessions, i.e., first exposure, 2nd exposure, and 3rd exposure. Furthermore, participants of dialogue meetings were also likely to have received similar messaging from other sources as different SBC strategies, such as posters and radio spots, among others were being implemented concomitantly in the community.

2.4 Eligibility criteria

A brief exit-interview tool was administered to a subset of persons taking part in the facilitated dialogue meeting to collect information regarding their reactions of the session, level of knowledge and attitude towards human rights, SRH, GBV and HTPs. A summary of study inclusion and exclusion criteria is provided

[1] These are defined as local community structures such as adolescent/youth groups, women groups, and men groups with a membership typically ranging between 10-50 individuals who regularly meet for different reasons including social-welfare and empowerment in business, farming, etc.

in table 2. Although, *Accelerate* program aims to reach in-school and out-of-school children from age 12 years with SBC messaging, the study excluded those who have not attained 15th birthday based on the following reasons. Firstly, children age 15 and below are not legally competent to provide consent or assent, secondly, securing parental consent can be challenging as they might be away from their homes at the time of data collection, thirdly, there are significant cognitive concerns that may limit comprehensibility of the tool among these young participants, and fourthly, standard GBV indicators such as those reported in the KDHS do not typically include this age category.

Once selected, an individual was included in the study only once and were excluded from future study participation even if he or she was reached repeatedly through dialogue meetings – in the same group or with another group.

We randomly selected study participants from some of the dialogue meetings. All participants provided informed consent/assent prior to administration of the survey.

Table 2: Study eligibility criteria

Inclusion	Exclusion
• A member of a localized group such as youth group, women group, or men group • Age 15 years and older • Reached with SBCC messaging on human rights, GBV, HTPs & SRHR, and physically attended dialogue meeting on the day of survey. • New respondent, not sampled in any of the previous study sample*	• Does not provide consent/assent to take part in the study

**It's possible an individual may have belonged to different groups and were not interviewed multiple times*

2.6 Data collection tool

A brief exit questionnaire and corresponding consent information forms were developed in English, and further translated into Swahili alongside other local dialects for use in the field (attached in the Annex 1). The exit questionnaire was programmed into an electronic data capture form compatible for mobile android devices, using Survey CTO platform. The tool was designed to capture limited data on respondent's demographic details such as age, level of education, religion, and marital status. We further collected information regarding awareness, and attitude towards GBV and harmful traditions such as child marriage and FGC, and their ability to exercise rights related to sexuality and contraceptive use. Where available, we used standard measurement questions and indicators as recommended by Measure Evaluation[2], University of North Carolina[3] or as used in large-scale demographic and health surveys such as Kenya Demographic Health Survey (KDHS).

3.0 Results

3.1 Sample description

In table 3, between January and December 2022, a total of 1,326 individuals were randomly selected for exit interviews after attending Accelerate SBC participatory meetings. Of these, 235 (18%) were men, 465 (35%)

[2] Measure Evaluation (2008) 'Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators'
[3] Data for impact, accessed from website, https://www.data4impactproject.org/prh/womens-health/adolescent-and-youth-sexual-and-reproductive-health/

women, and 626 (47%) adolescents – boys and girls. Sample size coverage was 90% or more among clusters including (South-West A and North-Rift, >100%; South-West B and South-West C, 93-94%), ranged 51-68% in North-Eastern and Coast, and was 38% in the Upper-Eastern cluster. Inability to achieve complete sample was challenged by widespread insecurity concerns particularly in the Upper-Eastern cluster, while there were operational challenges related to onboarding respective CBOs in the Coastal and North-Eastern clusters.

Table 3: Sample description by audience across study clusters by survey period, 2022

Audience	**South-West A** (KJD, NRK)	**South-West B** (Nairobi)	**South-West C** (Homabay)	**North-Rift**	**Coastal**	**Upper-Eastern**	**North-Eastern**	**All clusters**
2022 (Q1-Q4)	**N=242**	**N=226**	**N=223**	**N=258**	**N=163**	**N=92**	**N=122**	**N=1,326**
Men	41	38	39	46	31	13	27	**235**
Women	84	79	72	82	70	38	40	**465**
Adolescent (boys/girls)	117	109	112	130	62	41	55	**626**

3.2 Demographic information

Table 4 summarizes demographic information, such as education, religion, and marital status, among the interviewed respondent in 2022 (Q1-Q4). A large majority of sampled respondents reported having attained either secondary education (39%) or primary education (34%). Notably, clusters of North-Eastern (43%) and Upper Eastern (28%) reported highest rates of individuals with no formal education. Over half of respondents were protestant Christians (62%), a fifth were Catholics (20%), while only 16% were Muslims. All clusters were dominated by Christians, with exception of North-Eastern (Muslims, 99%). When asked about current marital status, 49% of respondents reported were not married (single), while 38% were married.

Table 4: Demographic data of interviewed respondents in 2022 (Q1 to Q4)

Characteristics	**South-West A** (KJD, NRK) **N=242**	**South-West B** (Nairobi) **N=226**	**South-West** (Homabay) **N=223**	**North-Rift** **N=258**	**Coastal** **N=163**	**Upper-Eastern** **N=92**	**North-Eastern** **N=122**	**All clusters** **N=1,326**
Highest level of education	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
None	14.1	0.0	0.0	0.8	8.0	28.3	42.6	**9.6**
Primary	42.2	3.5	60.5	25.6	49.0	27.2	29.5	**34.1**
Post-Primary/Vocation	1.2	1.3	2.7	14.0	1.8	0.0	0.8	**3.9**
Secondary	31.8	62.8	31.4	44.6	35.6	34.8	19.7	**39.1**
College	7.0	28.3	4.0	12.4	1.8	9.8	6.6	**10.7**
University	3.7	4.0	1.4	2.7	3.7	0.0	0.8	**2.6**
Religion	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Catholic	12.4	27.8	25.1	32.2	2.5	34.8	0.8	**20.3**
Protestant Christian	83.9	60.6	73.1	66.3	66.3	45.7	0.0	**62.1**
Muslim	2.5	8.0	0.5	0.8	29.5	19.6	99.2	**16.1**
No religion	1.2	3.5	0.9	0.8	1.8	0.0	0.0	**1.4**
Other	0.0	0.0	0.5	0.0	0.0	0.0	0.0	**0.1**
Marital status	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Currently married	46.3	23.5	37.7	39.9	41.1	38.0	42.6	**38.2**
Currently living with a partner	2.5	12.4	6.7	4.7	5.5	17.4	6.6	**7.1**
Formerly married	6.2	4.0	5.4	5.4	8.0	4.4	7.4	**5.7**
Not in union (Single)	45.0	60.2	50.2	50.0	45.4	40.2	43.4	**49.0**

**Indicator data collection begun in Q3/Q4. Sexual relationship was defined as currently married, live with a partner, or has a boyfriend/girlfriend.*

3.3 Exposure to SRH/GBV SBCC messages in the last 6 months

Overall, majority of respondents (72%) reported an exposure to SRHR/GBV messaging within the last 6 months (county range: 52-93%). The most cited sources for the message were the radio (35%), TV (26%), digital and social media (22%), community meetings (21%) and health providers/CHVs (20%) (Table 5).

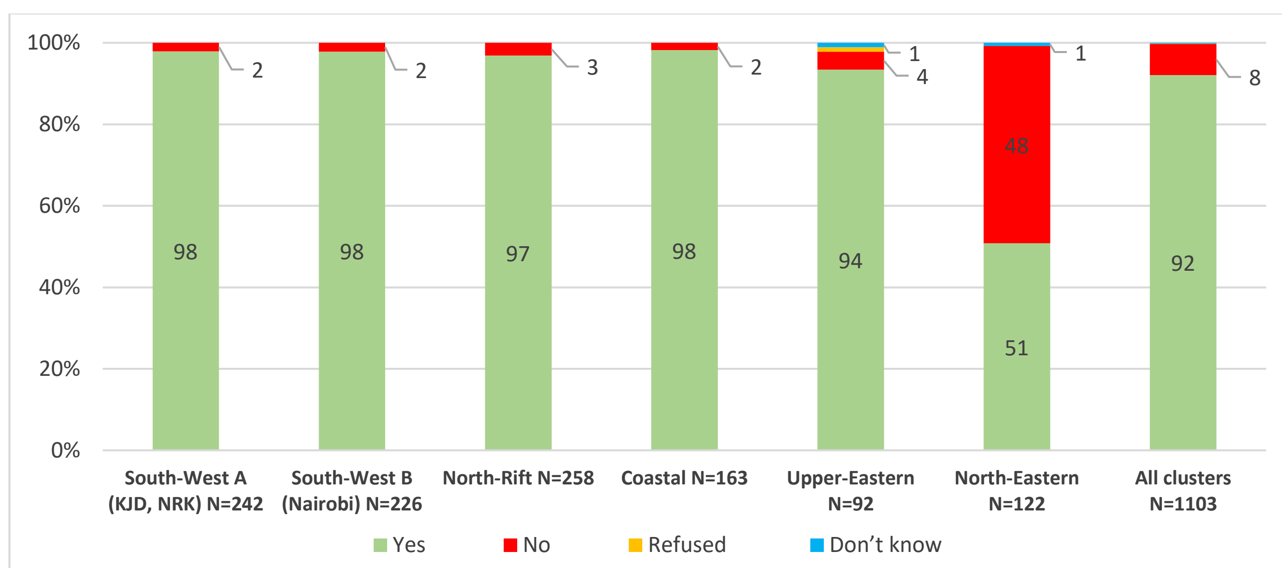
Table 5: Proportion of individuals exposed to targeted SBCC messages on SRH/GBV in the last 6 months, 2022 (Q1/Q2)

Characteristics	**South-West A** (KJD, NRK) **N=242**	**South-West B** (Nairobi) **N=226**	**South-West** (Homabay) **N=223**	**North-Rift N=258**	**Coastal N=163**	**Upper-Eastern N=92**	**North-Eastern N=122**	**All clusters N=1,326**
Exposure to SRHR targeted SBCC messaging such as "Ahadi yangu"	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Any source	83.1	93.4	65.0	54.7	51.5	77.2	82.8	**72.0**
Radio	34.3	39.8	37.2	31.1	3.7	40.2	63.9	**34.5**
TV	18.2	53.1	22.0	29.1	6.1	10.9	36.1	**26.6**
Poster/billboard	1.2	19.5	5.8	1.6	0.0	1.1	1.6	**5.1**
Pamphlet	0.0	8.9	1.4	0.0	0.0	0.0	2.5	**2.0**
Newspaper/ magazine	4.6	11.1	5.8	3.5	0.6	0.0	4.1	**4.8**
Digital media/ internet	14.5	60.2	17.0	20.5	1.2	9.8	13.1	**21.8**
Health provider/CHV	9.9	9.3	13.5	27.9	32.5	15.2	45.1	**20.3**
Meetings, other than *Accelerate*	50.4	16.4	11.2	10.1	20.3	28.3	10.7	**21.3**
Other duty bearers (teacher, chief, police, etc)	5.8	6.6	9.9	1.9	1.8	5.4	19.7	**6.6**
Male champion	0.4	0.0	0.5	2.3	2.5	0.0	3.3	**1.2**

3.4 Intention to have girls undergo FGM/C in the future.

In Figure 1, overwhelming majority (92%) of interviewed respondents reported that they do not intend to have any of their daughters to undergo female genital mutilation/cutting (FGM/C). However, almost one-half (48%) of respondents in North-Eastern cluster declared intentions to have their daughters undergo FGM/C in the future.

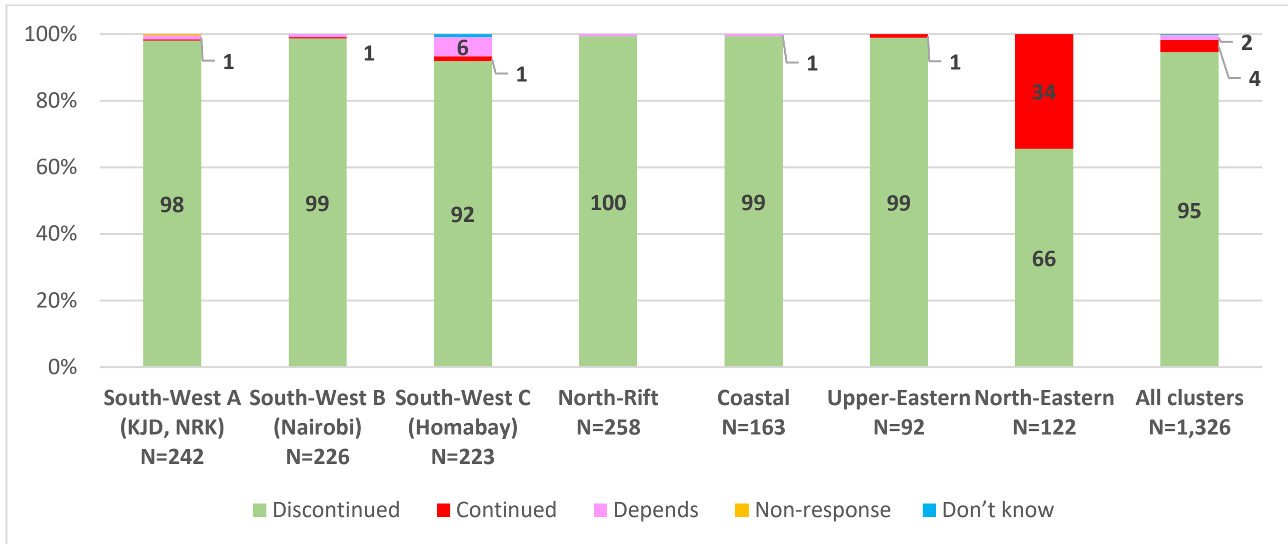
Figure 1: Proportion of people directly reached by the program who do not intend to have any of their daughters undergo FGM/C in 2022 (Q1-Q4)



3.5 Support to end child marriage

Overall, nearly all or 95% of respondents declared their support that marriage persons below age of 18 years should be stopped. However, one in three respondents (34%) in North-Eastern supported continuation of practices that promote marrying off persons below the age of 18 (Figure 2).

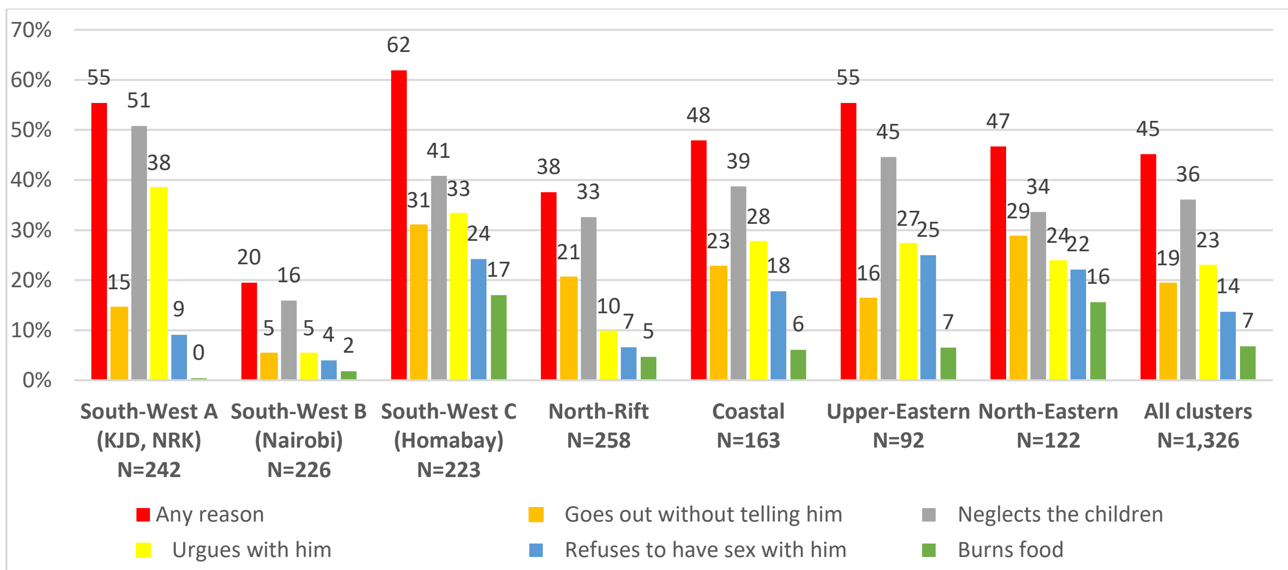
Figure 2: Proportion of individuals directly reached by the program who believe child marriage should be stopped in 2022 (Q1-Q4)



3.6 Endorsement of wife beating practices

Respondents were asked if a husband is justified in hitting or beating his wife under the following circumstances i) if she went out without telling him, ii) if she neglected children, iii) if she argued with him, iv) if she refused to have sex with him, and v), if she burnt the food. Overall, nearly half of the respondents (45%) affirmed that they endorsed a culture of wife beating for any of the stated reasons. Notably, neglecting the children was the most cited reason for justifying wife beating (36%), followed by arguing with him (23%) and going out without telling him (19%). Furthermore, cluster analysis showed findings varied substantially with endorsement ranging from 20% in Nairobi, 48% in Coast, 55% in South-West A (Kajiado/Narok) and Upper Eastern, to 62% in Homabay (Figure 3).

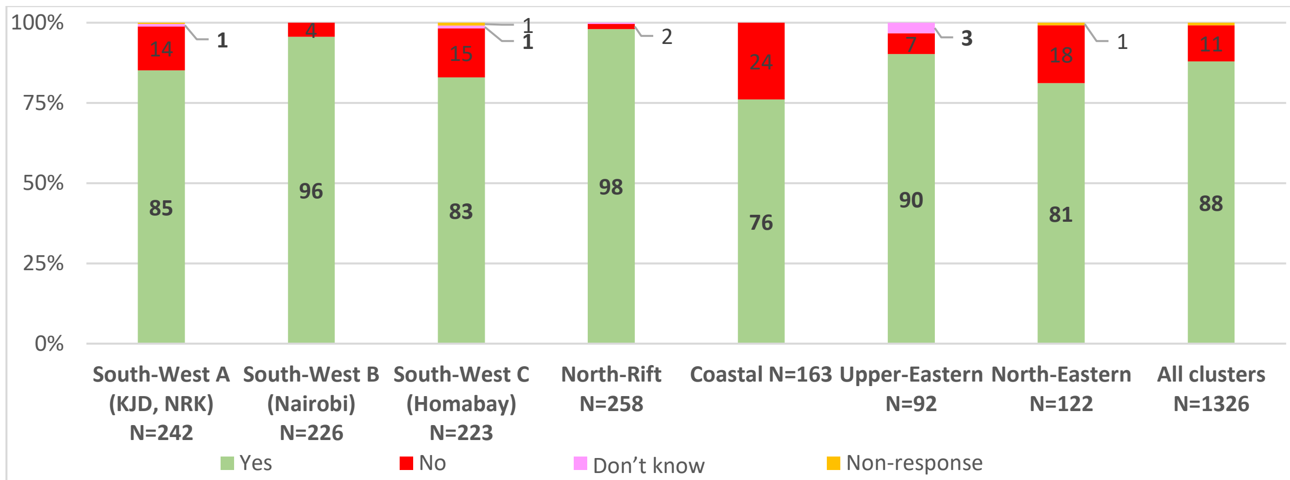
Figure 3: Proportion of individuals directly reached by the program who say that wife beating is an acceptable way for husbands to discipline their wives, by reason, 2022 (Q1-Q4)



3.7 Would assist a woman experiencing intimate partner violence (IPV)

In Figure 4, overwhelming majority, 88%, of the respondents reported they would assist a woman being beaten by their partner. However, approximately one-quarter of respondents in Coastal (24%) and North-Eastern (18%) mentioned they would not assist woman experiencing domestic violence.

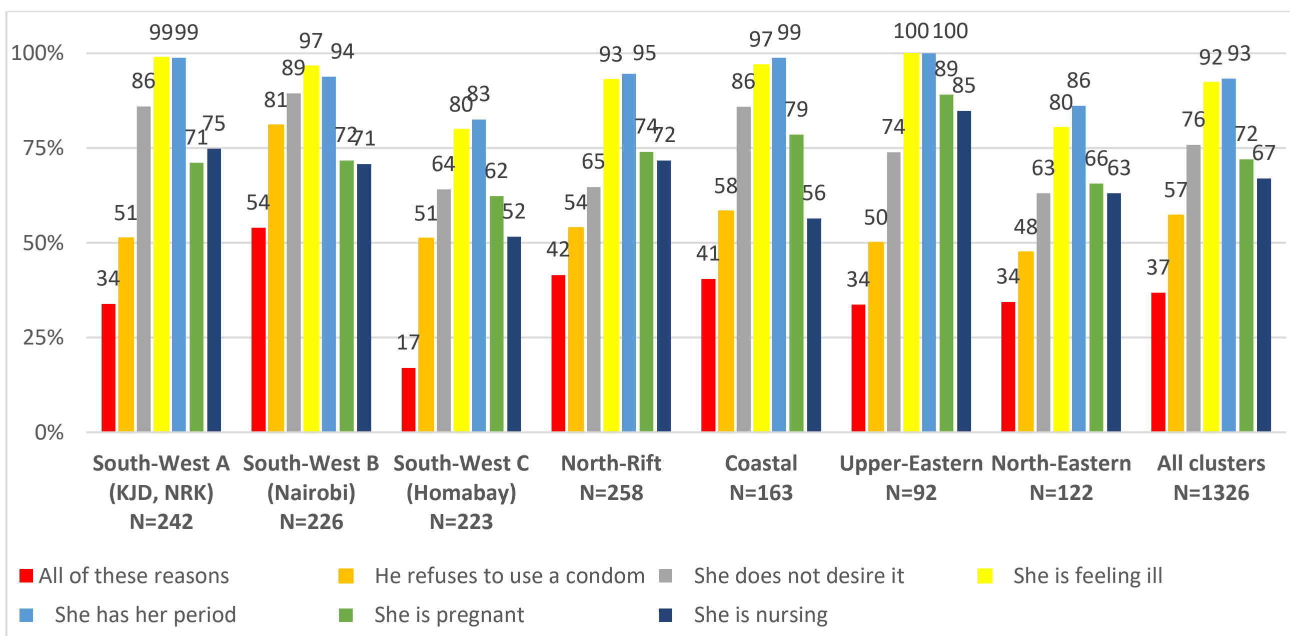
Figure 4: Proportion of individuals directly reached by the program who would assist a woman being beaten by her husband or partner, in 2022 (Q1/Q2)



3.8 Supporting female sexual autonomy

In Figure 5, to measure sexual autonomy, respondents were asked if a woman has a right to refuse sex if i) he refuses to use a condom, ii) she doesn't desire it, iii) she is feeling ill, iv) she has her period, v), she is pregnant, and vi), she is nursing. Overall, only 37% of respondents agreed that a woman has a right to refuse sex in all above-mentioned situations. Cluster responses ranged widely from just 17% in Homabay, 34% in Upper-Eastern, North-Eastern and South-West A (Kajiado/Narok), 41-42% in Coastal and North-Rift) to 54% in Nairobi. Overall, a reason of "he refuses to use a condom" was the least supported for a woman to decline sex (57%), followed by "she is nursing" (67%) and "she is pregnant" (72%).

Figure 5: Proportion of individuals directly reached by the program who agree that a woman has a right to refuse sex, by reason in 2022 (Q1-Q4)



3.9 Females' ability to exercise SRHR

Overall, 90% or more of adolescent girls self-reported they would tell someone if anyone touched their private parts (92%), believed they have the right to say no to sex, no matter who asks it (98%), and believed it was their right to say no to inappropriate sexual touch by anyone (98%) (Table 6).

Among partnered women and girls, slightly over two-thirds (69%) self-reported ability to say no to unwanted sexual activity to their partners (county range: 48%-79%). When asked about contraception use decision making, most participants reported it was mainly decided jointly with their partners (65%), while 24% and 8% mentioned it was mainly decided by themselves and their partner's, respectively.

Overall, about two-thirds (68%) of interviewed females reported ability to exercise a composite of SRHR indicator including they would report inappropriate sexual touching, decline inappropriate sexual touching and unwanted sexual activity.

Table 6: Exercising sexual and reproductive health and rights, among reached females in 2022.

Ability to exercise autonomy*	South-West A (KJD, NRK)	South-West B (Nairobi)	South-West C (Homabay)	North-Rift	Coastal	Upper-Eastern	North-Eastern	All clusters
Adolescent girls' self-reporting:	**N=76 %**	**N=74 %**	**N=76 %**	**N=89 %**	**N=46 %**	**N=30 %**	**N=34 %**	**N=425 %**
Agreed would tell someone if anyone touched my private parts	81.6	100	86.8	91.0	100	100	91.2	**91.8**
Agree I have the right to say no to sex, no matter who asks it	100	100	90.8	98.9	100	100	97.1	**97.9**
Agree have the right to say no if any male, including a teacher, family member, or friend wants to touch your thighs, buttocks, or private parts	100	100	93.4	98.9	100	93.3	100	**98.1**
Partnered women and girls' self-reporting¥: Ability to say no to unwanted sexual activity to their partners	**N=55 %**	**N=32 %**	**N=34 %**	**N=75 %**	N=27 %	**N=30 %**	**N=48 %**	**N=301 %**
Yes	72.7	68.8	76.5	78.7	48.2	60.0	60.4	**68.8**
No	5.5	18.8	20.6	12.0	44.4	40.0	37.5	**22.3**
Depends/Not sure	21.8	12.5	2.9	9.3	7.4	0.0	2.1	**9.0**
Partnered women and girls' self-reporting¥: Contraception decisions are mainly made był:	**N=51 %**	**N=32 %**	**N=30 %**	**N=75 %**	N=27 %	N=28 %	**N=45 %**	**N=288 %**
Myself	15.7	21.9	36.7	26.7	33.3	21.4	15.6	**23.6**
My partner and myself	80.4	62.5	40.0	73.3	55.6	46.4	68.9	**64.9**
My partner	0.0	15.6	3.3	0.0	11.1	21.4	15.6	**7.6**
Other responses	3.9	0.0	20.0	0.0	0.0	10.7	0.0	**3.8**
Ability to exercise sexual and reproductive health and rightsƛ	**N=80 %**	**N=68 %**	**N=68 %**	**N=88 %**	**N=45 %**	**N=36 %**	**N=74 %**	**N=459 %**
Yes	71.3	70.6	61.8	77.3	71.1	50.0	64.9	**68.2**
No	2.8	29.4	38.2	22.7	28.9	50.0	35.1	**31.8**

** Data collection was initiated in Q3/Q4. Denominator includes non-missing female observations.*
¥ Women who are currently in a heterosexual relationship i.e., married, lives with a partner, or has a boyfriend.
ł Denominator includes respondents of reproductive age i.e., 15-49 years
ƛ Composite indicator was defined as adolescent girls who would report and say no to inappropriate sexual touch and believed they have a right to say no to sexual activity no matter who asks; partnered women and girls who reported ability to say no to sexual activity to their partners and involvement in contraception decision making.
Greyed results are computed based on a small denominator (N<30), thus may be inaccurate.

3.10 Contraceptive attitudes and practices

Overall, almost one-half (49%) of respondents aged 15-49 years and currently in a sexual relationship self-reported use of contraceptive at last sexual activity (Table 7). This finding varied widely by county, with contraceptive use reports ranging from just 16% in North-Eastern, 40-45% (Nairobi, Kajiado/Narok and Homabay), 55-59% in Coastal and Upper-Eastern, to 71% in the North-Rift.

Among 225 interviewed males, more than one-third (31%) agreed with the statement that *"contraception is a woman concern, and they should not worry about"* (county range: 4% in Coastal cluster to 66% in Homabay). A quarter (25%) of the males affirmed they believed that "*women or girls who use contraception may become promiscuous"* (county range: 9% in Coastal cluster to 31-33% in North-Rift and Kajiado/Narok).

Table 7: Contraception attitudes and practices in 2022 (Q3/Q4)

FP attitudes and practices*	South-West A (KJD, NRK)	South-West B (Nairobi)	South-West C (Homabay)	North-Rift	Coastal	Upper-Eastern	North-Eastern	All clusters
If aged 15-49 years and currently in a sexual relationship, they, or partner, used a contraceptive method during the last sexual activity**	**N=87**	**N=47**	**N=47**	**N=116**	**N=40**	**N=39**	**N=67**	**N=443**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Yes	43.7	40.4	44.7	70.7	55.0	59.0	16.4	**48.8**
No	56.3	59.6	55.3	27.6	40.0	38.5	82.1	**49.9**
Can't remember/don't know	0.0	0.0	0.0	1.7	2.5	0.0	1.5	**0.9**
Refused	0.0	0.0	0.0	0.0	2.5	2.6	0.0	**0.5**
Males who believe contraception is woman concern and they should not worry¥	**N=40**	N=26	N=29	**N=45**	N=23	N=16	**N=46**	**N=225**
	%	%	**%**	**%**	**%**	**%**	**%**	**%**
Agree	25.0	19.2	65.5	42.2	4.4	37.5	21.7	**31.1**
Disagree	70.0	80.8	34.5	57.8	95.7	62.5	78.3	**68.0**
Don't know	5.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.9**
Males who believe women or girls who use contraception may become promiscuous¥	**N=40**	N=26	N=29	**N=45**	N=23	N=16	**N=46**	**N=196**
	%	%	%	**%**	**%**	**%**	**%**	**%**
Agree	32.5	23.1	17.2	31.1	8.7	18.8	13.0	**24.9**
Disagree	50.0	76.9	48.3	66.7	91.3	81.3	87.0	**67.0**
Don't know	17.5	0.0	34.5	2.2	0.0	0.0	0.0	**8.0**

**Data collection was initiated in Q3/Q4.*
***Sexual relationship was defined if respondent is currently married, live with a partner, or has a boyfriend/girlfriend.*
¥ Denominator includes non-missing male observations.
Greyed results are computed based on a small denominator (N<30), thus may be inaccurate.
NS= no male sample was included in the reporting period (Q3/Q4)

3.11 Awareness of locally available support services for a female GBV survivor

In Table 8, female respondents were asked if they knew a facility or an organization, a toll-free line, or a place where survivors of gender-based violence (GBV) can locally receive social and welfare services. Overall, slightly over one-half (54%) of women and girls knew a local resource where a GBV survivor can seek care and support. Awareness of locally available GBV resources differed substantially across the clusters ranging from just one-third of respondents in Nairobi (30%), 40-46% in Upper Eastern and Homabay, 60-64% in North-Rift and South-West A (Kajiado/Narok), to 80% in the Coastal cluster. Overall, among those who knew a GBV care and support resource, health facility (48%), police (46%) and chief (32%) were the most mentioned places. CHVs were commonly mentioned among respondents in North-Eastern (46%) and coastal (20%) clusters.

Table 8: Proportion of females reached by the program who knew a local resource available for GBV survivor, 2022 (Q1 to Q4)

Knowledge of social welfare services available for a female GBV survivor	South-West A (KJD, NRK) N=160	South-West B (Nairobi) N=153	South-West C (Homabay) N=147	North-Rift N=171	Coastal N=116	Upper-Eastern N=68	North-Eastern N=74	All clusters N=889
	%	%	%	%	%	%	%	%
Yes, names a facility/resource	64.4	30.1	46.3	59.7	80.2	39.7	59.5	**54.3**
No, doesn't know	35.6	69.9	53.1	40.4	19.8	60.3	40.5	**45.6**
Non-response	0.0	0.0	0.7	0.0	0.0	0.0	0.0	**0.1**
Among those who knew a GBV resource, name of the social welfare resource*	**N=57**	N=10	**N=43**	**N=66**	**N=40**	N=24	**N=44**	**N=284**
	%	%	%	%	%	%	%	%
Health facility	21.1	60.0	46.5	63.6	27.5	62.5	70.5	48.2
Police	31.6	20.0	39.5	50.0	55.0	87.5	38.6	45.8
Chief and other officers	80.7	10.0	16.3	3.0	17.5	62.5	29.6	32.0
CHV	1.8	0.0	2.3	0.0	20.0	4.2	45.6	10.9
Religious leader	3.5	0.0	9.3	1.5	2.5	16.7	27.3	8.5
GBV hotline	1.8	0.0	4.7	0.0	0.0	0.0	18.2	3.9
Cultural leader	0.0	0.0	4.7	0.0	0.0	0.0	11.4	2.5

**Multiple resources were mentioned and data collection for this indicator began in Q3 of 2022*
Greyed results may be unreliable given that a smaller sample size (N<30) was used to compute the estimate.

3.12 Awareness of legal prohibitions related to rights of women and girls

The government of Kenya has enacted laws which criminalizes practice of female genital mutilation/cutting (FGM/C), child marriages, and domestic violence. Overall, there was high awareness of law criminalizing practices of FGM/C (93%) and child marriages (95%) and wife beating (91%). However, in North-Eastern where FGM/C rates are among the highest in the country, only two-thirds (66%) of the respondents were aware that the practice was outlawed (Table 9).

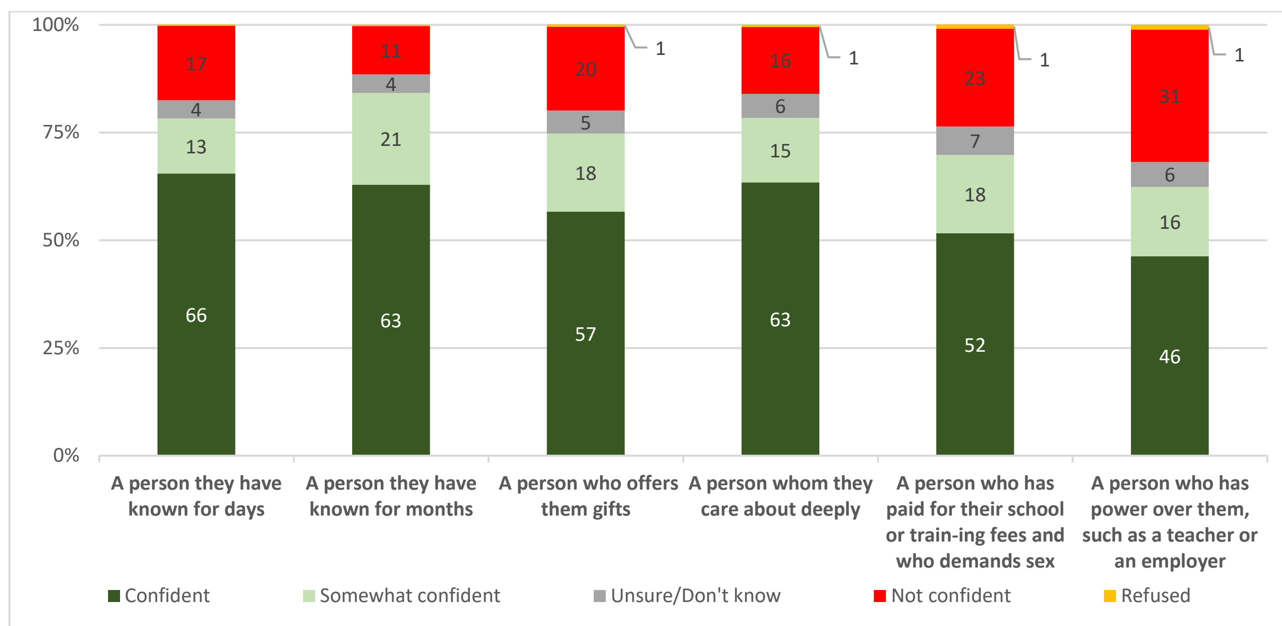
Table 9: Proportion of people directly reached by the program who knows of legal prohibitions to protect women and girl's rights, 2022 (Q1-Q4)

Knows legal prohibitions to protect women and girl's rights.	South-West A (KJD, NRK) N=242	South-West B (Nairobi) N=226	South-West C (Homabay) N=223	North-Rift N=258	Coastal N=163	Upper-Eastern N=92	North-Eastern N=122	All clusters N=1,326
	%	%	%	%	%	%	%	%
Knows all the 3 prohibitions	89.3	98.2	66.8	96.9	96.9	82.6	61.5	86.4
FGM/C is outlawed	96.7	96.6	81.2	99.6	99.4	97.8	65.6	92.7
Child marriage is outlawed	97.9	99.6	86.6	99.6	100.0	95.7	79.5	95.0
Wife beating is outlawed	90.9	98.2	80.7	96.9	97.6	82.6	79.5	90.8

3.13 Adolescents and youth confidence negotiating safer sex

Adolescents and young adults (boys and girls, aged 15-23 years) were asked if a sexual intercourse was involved would they convince their partner(s) to use contraceptive/condom if they desired. Overall, as high as 66% of boys and girls reported being confident that they could convince use of a condom or contraceptive if sexual activity involved a person whom they knew for a few days, 63% if they had known the person for months or a person whom they deeply care about. However, less than one-half of the respondents (46%) expressed confidence that they could get a person who has power over them to use a condom or contraceptive.

Figure 6: Proportion of adolescents and young adults (girls & boys) directly reached by the program who are confident that they could get their partner(s) to use contraceptives or condoms if they desired (N=626)



4.0 Study limitations

There are a few limitations to this study, including:

- The survey experienced sampling inadequacies in some of the clusters given that there were few SBCC dialogue events to recruit study participants from. Inability to meet the required sample size was experienced in North-Eastern, Upper-Eastern, and the Coastal cluster.
- Cross-sectional design limits the ability to compare individual and community level changes over time given that different group of respondents are sampled at each survey, and from different areas which may have had different doses of exposure to program interventions.
- Given respondents were interviewed immediately after SBCC session, survey responses related to attitude and practices could have been influenced by social desirability bias.
- While standard measures of some aspects of SRHR and violence exist, many have not been validated especially those related to knowledge and ability to exercise sexual autonomy.

5.0 Conclusions and recommendations

The presented results indicate several important gaps in the efforts to promote SRHR, gender equality and awareness of human rights. In table 10, we provide of a summary of recommendations to help address identified gaps.

Table 10: Conclusions and recommendations

Conclusions	Recommendations
❖ While there was high awareness of law which criminalize practices of FGM/C (93%), child marriages (95%), and wife beating (91%), violence against women and girls was highly endorsed by the communities. Nearly half of interviewed respondents (45%) endorsed a culture of wife beating, and practice of FGM/C and early marriages were widely supported by North-Eastern respondents. ❖ Women and girls have low sexual autonomy with just one-third (37%) of interviewed respondents believing that a woman has a right to refuse sex if male partner refuses to use a condom, when she doesn't desire it, feels unwell, has period, or when the woman is pregnant or nursing. More than one-third (31%) of partnered women and girls reported inability to say no to unwanted sexual activity to their partners. ❖ Slightly more than one-half of interviewed females (54%) knew a place, by name, where a survivor of GBV can locally seek for care and support.	• Multi-prong strategies should be scaled up to address deep seated traditions which tolerate, endorse, and normalize violation of sexual rights, and other forms of gender-based violence. Among these, should include county specific SBCC interventions which address enablers of GBV from socio-cultural and religious perspectives. Effective engagement of community cultural and religious leaders, other grassroot leaders and opinion shapers is paramount to shifting social norms around SRHR/GBV. • All grassroot duty bearers, including community health workers/CHVs, police and local administrators/chiefs should be trained to sensitize communities on prompt, appropriate reporting, and care-seeking behaviours among GBV survivors. • Strengthening of existing local systems should be prioritized, including surveillance systems to monitor and report all forms of GBV including sexual violence, FGM/C, and child marriages. Furthermore, all facilities offering GBV services should be supported to promote uptake of services, including active case finding through routine screening of women seeking other health services, and initiating linkage to auxiliary support services such as access to justice and rescue/sheltering to prevent further violence.

❖ While about half (49%) of interviewed respondents (15-49yrs) self-reported contraception use at last sexual intercourse. Negative contraception attitudes are prevalent among males, including believe that contraception is a woman concern and women/girls who use contraception may become promiscuous. ❖ A moderate proportion of adolescents and young adults (46-66%) self-reported confidence or "perceived self-efficacy" in ability to negotiate for condom/contraceptive use with sexual partner (s) whey they desired.	• Scale up of male engagement interventions should be implemented to address gender inequalities related to sexual and contraception autonomy. Customized contraception dialogue interventions should be considered to address myths and misinformation that promote negative contraception attitudes particularly among male partners. • Adolescents and young adults should be reached with age-appropriate and comprehensive sexual education (CSE) through multiple channels including digital/social media platforms, youth events, school programs, and traditional channels of mass media such as radio talk shows. Furthermore, efforts should be made to ensure young people are adequately reached with non-biased, youth-friendly, and high quality SRHR services and products through local health facilities or community-based activities as offered by CHVs and CBOs.

6.0 References

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7.0 Annex - Questionnaire

Section 1a: County information [complete this section for all respondents.]
C1. Start date and time / End time [captured automatically by the device] Date: [___|___]-[___|___]-[___|___|___|___] Time (in 24hr clock) : [___|___] : [___|___]
C2. Interviewer's name [____]
C3. County [____]
C4. Sub-county [____]
C5. Meeting location (village name/town/shopping centre/school name, etc). **Do not write people's name or places of residence.** [____]
Section 1b: Screening and Consenting [*complete this section for <u>all</u> respondents]*
Instructions: At the end of the SBCC session, Interviewer to fill a separate form for each sampled participant. You'll be required to find a private space where conversation can be held to maintain privacy and confidentiality of information. Conversation should NOT proceed if the privacy or confidentiality cannot be maintained.
Introduction: Hello, my name is _______ and I am conducting interviews today on behalf of Population Services Kenya (PS Kenya). We are randomly selecting a few participants from the meeting to receive their perspectives regarding the topics that were discussed. First, I will ask a question to determine your participation eligibility.
SC1. DO NOT ASK: SBCC target audience *1= Men* *2= Women* *3= Adolescents/Youth* [___]
SC2: DO NOT ASK: CBO was reaching this group for the_____________dialogue meeting? *1= initial/First* *2= Second time* *3= Third time* *4 = More than 3 times* [___]
SC2A. Is the sampled respondent available for interviews? 1=Yes 0=No, declined/refused/Time not convenient [___]
SC3. DO NOT ASK, Observe: Respondent gender *1= Male* *2= Female* [___]
SC4. Have you in the past participated in an **ACCELERATE** Exit-interview, immediately after attending your dialogue meeting? *1= Yes (Interviewer: probe further to confirm, Terminate interview)* *0= No* *7= Don't remember (Interviewer: probe further to confirm)* [___] **If YES. Probe to confirm, Thank the respondent and terminate the interview**
SC5. How old were you at your <u>last birthday</u>? In years. ***If <15 years, Thank the respondent and terminate the interview*** [___|___]

SC6. **Instructions**: Hand over the consent/Assent information document. Read out aloud the consent information in the preferred local language. Give participant time to ask questions before seeking for their verbal consent/Assent.

Have you gained informed verbal consent/assent? [___]

1= Yes, Assent (less than 18 yrs)
2= Yes, Consent (18 and over yrs)
7= NO – Declined/Unsure/Need to consult some else
IF NO, Thank the respondent and terminate the interview

Section 2: Demographic information [*complete this section for all respondents]*

D1. What is the highest level of school you attended: primary, vocational, secondary, or higher? [___]

[for those still in school, ask about current level and comment at the end of the interview]

None. 0
Primary 1
Post-Primary/Vocational 2
Secondary 3
College. 4
University. 5

D2. What is your religion? [___]

Catholic 1
Protestant/ Other Christian 2
Muslim. 3
No Religion 4
Other specify [___________________________]. 96

D3. Have you ever been married or lived together with a man/woman as if married? [Read out options] [___]

YES, currently married. 1
YES, currently living with a partner. 2
YES, FORMERLY MARRIED 3
NO, NOT in union. 4

D4. [If D3=3 or D3=4], Do you currently have a boyfriend or girlfriend or partner? [___]

1=Yes 0=No 97=Refused

D5. The last time you had sexual intercourse, did you or your partner do something or use any method to delay or avoid a pregnancy? Read out responses [___]

1=Yes 0=No 88=Not yet sexually active 99=Don't know/Can't remember 97=Refused

Section 3: Exposure to SBCC messaging and feedback [*complete this section for all respondents]*	
E1. In the last 6 months, how many times have you attended such **[Accelerate]** dialogue meeting discussing issues of sexual reproductive health and gendered human rights? [Read out responses] *1= Today was first time 2= Today was second 3= Today was 3rd time 4 = More than 3*	[___|___]
E2. In the last 6 months, have you heard or seen any message on sexual reproductive health or gendered human rights such as "Ahadi yangu campaign"? Where did you hear or see that? *[mark YES for all spontaneous responses]*	
a) Never heard/seen	[___]
b) Radio	[___]
c) TV	[___]
d) Poster/Billboard	[___]
e) Pamphlet	[___]
f) Newspaper/magazine	[___]
g) Digital/Internet/social media platforms such as FB, WhatsApp	[___]
h) From health provider/CHV	[___]
i) From duty bearer e.g., teachers, chief, police officer, community leaders	[___]
j) From male champions	[___]
k) Other Meetings which are not Accelerate	[___]
l) Other (specify) [______________________________]	[___]

Section 4: Knowledge and Attitudes – GBV/HTPs	
K1a. **[For women and Girls only].** Do you know a facility or an organization, or a place where a woman/girl survivor of gender-based violence (GBV) can receive social and welfare services in this community? If no, probe further *1=Yes, names a facility/place 0=No/don't know 97=refused*	[___]
K1b. If yes, name the facility/organization? [____]	
K1c. [Interviewer] Code the named facility or organization. *[Multiple responses allowed]*	
a) Health facility	[___]
b) CHW	[___]
c) GBV hotline number	[___]
d) Police	[___]
e) Chief or another government administrator	[___]
f) Religious leader	[___]
g) Cultural leaders	[___]
h) Other	[___]
K2. [For ALL] In your opinion, is a husband justified in hitting or beating his wife in the following situations? *1=Agree 0=Disagree 99=Don't know 97=refused*	
a) If she goes out without telling him?	[___]
b) If she neglects the children?	[___]
c) If she argues with him?	[___]
d) If she refuses to have sex with him?	[___]
e) *If she burns the food?*	[___]
K3. [For ALL] If you knew that a woman was being beaten by her husband, either because you heard the incident(s) or because she told you, would you be willing to help her? *1=Yes 0=No 99=Don't know 97=Refused*	[___]

K4. [Do not ask in non-FGC area (Homabay)], For ALL] In some countries, there is a cultural practice in which a girl may have part of her genitals cut/female circumcision. Do you feel that female circumcision should be continued, or should it be discontinued?

1=Continued 0=Discontinued 88= Depends 99=Don't know 97=Refused [___]

K5. [Do not ask in non-FGC area (Homabay)], For ALL]. If you have/had a young girl or a close female relative, would you intend to have her undergo female cut (circumcision) in the future?

1=Yes 0=No 99=Don't know 97=Refused [___]

K6. [For ALL] Do you feel that child marriage, that is, the marriage of a person who is under the age of 18, should be continued, or should it be discontinued?

1=Continued 0=Discontinued 88= Depends 99=Don't know 97=Refused [___]

Section 5: Knowledge and Attitudes – SRHR

S1. [Adolescent Girls] If someone, even a family member, had touched your private parts, would you be willing to tell someone about it?

1=Yes 0=No [___]

S2a. [Adolescent Girls] Do you agree or disagree with the following statements?

1=Agree 0=Disagree 99=Don't know 97=refused

a) You have the right to say no to sex, no matter who asks you [___]

b) You have the right to say no if any male, including a teacher, family member, or friend wants to touch your thighs, buttocks, or private parts) [___]

S2b. [Among partnered women & girls] Can you say no to your husband/partner if you do not want to have sexual intercourse?

1=Yes 0=No 88=Depends/Not sure 97=Refused [___]

S2c. [Among partnered Women & girls] Would you say that using contraception is mainly your decision, mainly your (husband's/ partner's) decision, or did you both decide together? [___]

1=Mainly respondent 2=Mainly partner/husband 3=Mainly joint decision/decide together
96=Other specify [___________________________]

S2d. [Ask if, D3=1 or D3=2] Who usually makes decisions about HEALTH care for yourself?

1=You 2=Your partner/husband 3= You and your partner/husband 4=Parents [___]
96=Some else specify [___________________________]

S3. [For ALL] Do you agree or disagree with the following statement: It is okay for a woman to refuse to have sex with either her partner or husband if:

1=Agree 0=Disagree 99=Don't know 97=refused

a) He refuses to use a condom [___]
b) She does not desire it [___]
c) She is feeling ill [___]
d) She has her period [___]
e) She is pregnant [___]
f) She is nursing [___]

S4. [Adolescents only, boys/girls] In the following situation, would you say that you are "confident", "somewhat confident", "unsure", or "not confident" that you could convince partner(s) to use a contraceptive/condom if you desired?

Probe: "This is hypothetical, and not about your own experience. Please think about your response when you think about a hypothetical person who is in this situation."

1=Confident 2=Somewhat confident 3=Unsure/don't know 4=Not confident 97=Refused

a) A person they have known for days	[___]
b) A person they have known for months	[___]
c) A person who offers them gifts	[___]
d) A person whom they care about deeply	[___]
e) A person who has paid for their school or train-ing fees and who demands sex	[___]
f) A person who has power over them, such as a teacher or an employer	[___]

S5. **[For ALL**] Would you agree or disagree with the following statement?

1=Agree 0=Disagree 99=Don't know 97=refused

a) Female genital cutting (circumcision) is an outlawed practice	[___]
b) Marriage of a person below age of 18yrs is outlawed	[___]
c) Wife beating is outlawed	[___]

S9. **[For Men and Boys**] I will now read you some statements about contraception. Please tell me if you agree or disagree with each one

1=Agree 0=Disagree 99=Don't know 97=Refused

a) Contraception is a woman's concern, and a man should not have to worry about it	[___]
b) Women or girls who use contraception may become promiscuous	[___]

Section 6: Ending the Interview [All respondents]

S6. DO NOT ASK: Where did the dialogue/SBCC meeting take place?

1= Indoor venue which is not a participant home or premise/property
2= Outdoor venue/space which is not a participant home or premise/property
3= Indoor venue which in a participant home or premise/property
4= Outdoor venue/space which in participant compound or premise/property

[___]

S7. DO NOT ASK: In reference to finding a private space, would you say for the current interview I…

1= Found a private space for both visual and audial privacy
2= Found a private space for audial privacy only
3= I could not find a private space at all
96= Other specify [________________]

[___]

S8. Take GPS readings,

if meeting took place away from member's home or property (S6=1 or S6=2)

[____]

Main language of the interview

1=Borana
2= English
3=Kalenjin
4=Luo
5=Maasai
6=Pokot
7=Swahili

[___]

Record outcome of the interview	
1= Completed interview 2= Partly completed due to lack of privacy 3= Partly completed due to lack of time 4= Partly completed due to participant refusal 5= Ineligible - less than 15 years 6= Ineligible - previously interviewed 7= Sampled respondent not available 97= Sampled respondent did not consent - refused 96= Other specify [________________]	[___]
Briefly record relevant comments (Optional - record when it's important)	
Thank the respondent for their time. **End the form, validate before submitting the record**	