BINTI BIASHARA

(*JIWEZESHE KWA MPANGO*)

PATHWAYS OUT OF POVERTY

ECONOMIC EMPOWERMENT INTEGRATION TO AYSRH

Supporting young mothers in Kilifi- Magarini Sub County by providing more substantial economic empowerment support while maintaining critical linkages to AYSRH services.

MAVERICK COLLECTIVE

Project Name	MAVERICK*NEXT* – BINTI BIASHARA
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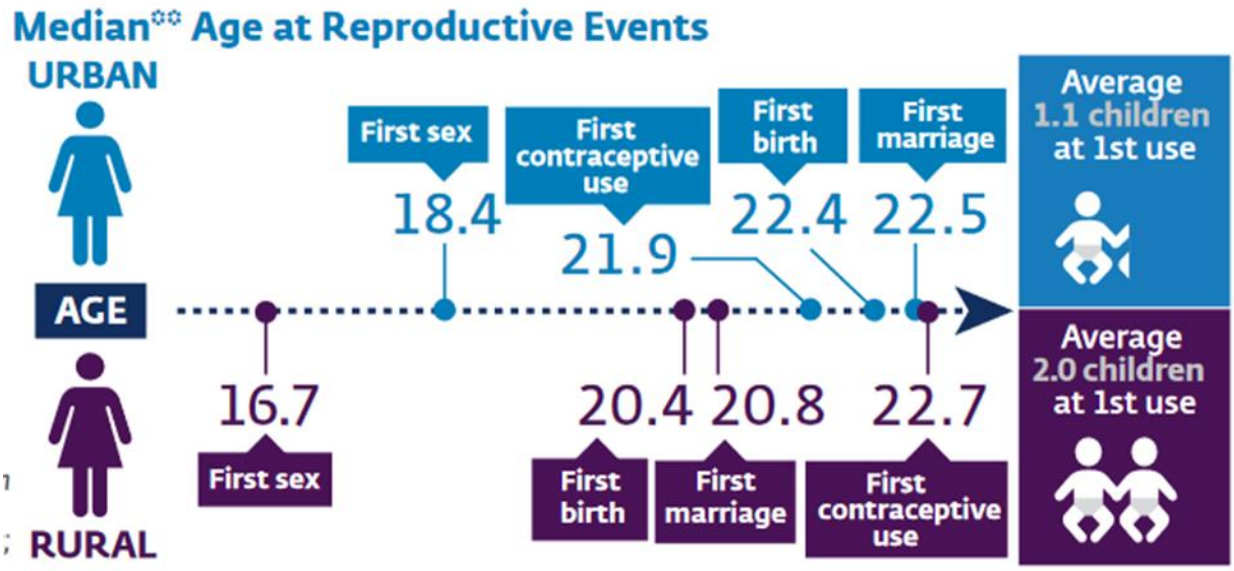
MAVERICK NEXT – BINTI BIASHARA – NARRATIVE REPORT

EXCECUTIVE SUMMARY

In Kenya, as in other parts of Sub-Saharan Africa, adolescents face severe challenges to their lives and general well-being. They are vulnerable to early and unintended pregnancy, unsafe abortion, female genital mutilation (FGM), child marriages, sexual violence, malnutrition, reproductive tract infections including sexually transmitted infections (STIs) and HIV and AIDS. Kenya has a large population of young people, with about 69% below the age of 30 years, of which 22% are adolescents 15-19 and 32% being 10-24 years old. This validates that Kenya is truly a Youthful Nation. Nearly 20% of girls begin child-bearing before the age of 20 (KDHS, 2014).

Many young people in Kilifi are sexually active with the median age of first sexual intercourse reported to be 18.4 years for females and slightly lower, 17.7 years, for males. While nearly all sexually active girls in the country report wanting to prevent pregnancy, a large majority, 59%, of these adolescents did not have access to contraceptives when they needed them. This is more than double the national average unmet contraceptive need for this age group which is at 23%.



Deep in the rural Kenyan coast in Kilifi- Magarini Sub County we encounter Pendo. At 19 years old, she is a class eight school dropout, married and mother to a 4-year-old, forming part of 59% of adolescent girls in Kilifi County that did not have access to contraceptives when they needed them. This is more than double the national average of adolescent girls who have unmet need for contraception (they want to prevent pregnancy but do not have access to contraception). In

2018 alone, a total of 17,580 adolescent and youth pregnancies were reported in the county (DHIS 2 Kilifi County Data, 2018).

There are a number of reasons for this particularly high rate of unmet need for contraception in Kilifi County. The main challenge is brought about by the ever-growing need for social services such as health, education, meaningful employment opportunities and other social amenities. Kilifi, being one of the poorest counties in the nation – with poverty rates that triple the national average -- healthcare facilities are located far from where girls reside. Eighty-percent of the county is rural, and only 13% of residents have secondary level education (Society for International Development (SID), 2019). The level of unemployment in Kilifi County has remained high since independence but has worsened due to the recent tourism industry recession. While Vision 2030 Medium Term Plans (MTPs) target boosting the creation of high-productivity wage jobs as well as supporting of the non-farm self-employed sector, a large proportion of the county population still engages in subsistence family farming and low-productivity self-employment (CIDP 2018-2022).

Social and cultural norms dictate that girls prove their fertility early, placing messages about contraception at odds with what society expects of them. Most complex, however, is the link – or lack thereof -- that girls and their families make between poverty and child-bearing. With such deep levels of poverty, girls like **Pendo** are worried about sourcing their next meal, not their sexual and reproductive health. With few job opportunities or examples of how to break out of poverty, rates of transactional sex (sex in exchange for money or goods) are high among girls and young women. Furthermore, Pendo and her peers see motherhood as the only certain way of gaining status in their communities. Without an alternative – such as the ability to bring in income for their family – messages about preventing pregnancy don't resonate.

BACKGOUND

PS Kenya is a local NGO whose mission is to improve the health of Kenyans by promoting functional and sustainable systems and increasing access to quality health solutions. PS Kenya employs a total market approach (TMA) that focuses on understanding barriers to use of health products and services and addresses the capacities and incentives of government and key market players to improve market performance. This is in line with the organizations' vision – to lead in strengthening health markets and empowering every Kenyan to make healthy choices.

Since 2017, with support from **Maverick Collective member Ann Morris**, PS Kenya has been working closely with county health officials in Kilifi County though a parent intervention – Project Riziki – to train and certify a cadre of non-medical community health workers who can provide education and contraceptive services at the community level – so that women do not need to travel all the way to health facilities. Huge strides have been made in advocating for policy change so that these community health volunteers can provide both short-acting contraceptive methods (e.g., oral contraceptive pills, injectables) as well as contraceptive implants which last up to five

years. This project in Kilifi County transformed the way contraceptive service delivery has typically been done in Kenya – **bringing care much closer to the doorstep of the women who need it most**, yet struggle most to access it.

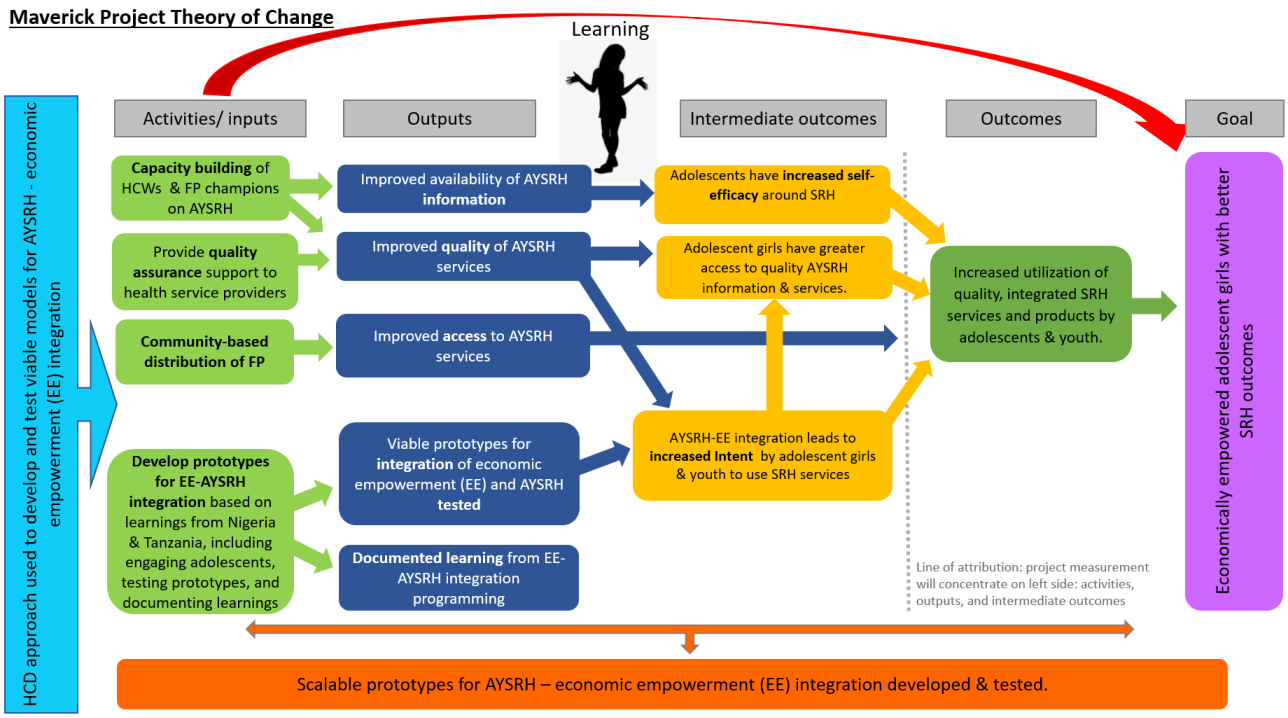
Binti Biashara is the subsequent intervention that is supported by **Maverick*NEXT* fellows** and was built upon the achievements and learnings of Project Riziki, Smart Start and a number of other existing tools already being used in Kenya, as well as other countries with similar programs like Ethiopia, Tanzania, and Nigeria.

THEORY OF CHANGE

While utilization of family planning services has increased significantly since the launch of the Project Riziki, unmet need for contraception remains high, particularly in Magarini Subcounty of Kilifi, thereby directing attention toward more **distal, structural factors** hindering young women's SRH choices and economic well-being.

A young woman's ability to make strategic SRH decisions and act on those choices relates to her economic well-being, as evidenced by studies linking **young women's empowerment to improved SRH behaviors and outcomes** (Prata et al., 2017), including use of contraception (Bose and Heymann, 2019; Ewerling et al., 2017; James-Hawkins et al., 2016; Yaya et al., 2018), prevention of unintended pregnancy (Upadhyay and Hindin, 2005), receipt of antenatal care (Mistry et al., 2009), improved maternal dietary practices (Gram et al., 2019), delivery with a skilled birth attendant (Shimamoto and Gipson, 2015), and negotiation in sexual relationships (Pearson, 2006; Wolff et al., 2000).

This concept also aligns with the global evidence and frameworks on **positive youth development** (PYD) that suggests that providing young women with more substantive support to achieve their financial and life goals could have multiple benefits – including improving young women' economic empowerment, power and SRH outcomes.



PROJECT GOAL

Firstly, the project's research & learning agenda was to come up and test **valid prototypes** that successfully help adolescent girls and young women build the intellectual and financial assets they need to find pathways out of poverty and empower them to make the best decisions for their futures and those of their families.

Secondly, the project worked toward **long-term sustainability** with policy change as a cornerstone of its success.

OUR APPROACH:

HUMAN-CENTERED DESIGN (HCD)

HCD is a process that uncovers human needs and aspirations and unlocks new opportunities in order to create holistic solutions that meet the needs of the users, beneficiaries and stakeholders.

The design process of *Binti Biashara* included rigorous Human-centered design approaches and meaningful youth engagement that generated context-specific insights that allowed the design team to understand how the interplay of adolescent and young mothers' development (biological, cognitive, social, emotional, and sexual), youth culture, and sexual norms affect

AYSRH behavior in specific cultural contexts and apply that understanding to the models that were developed.

DESIGN OPPORTUNITY & UNDERLYING ASSUMPTIONS

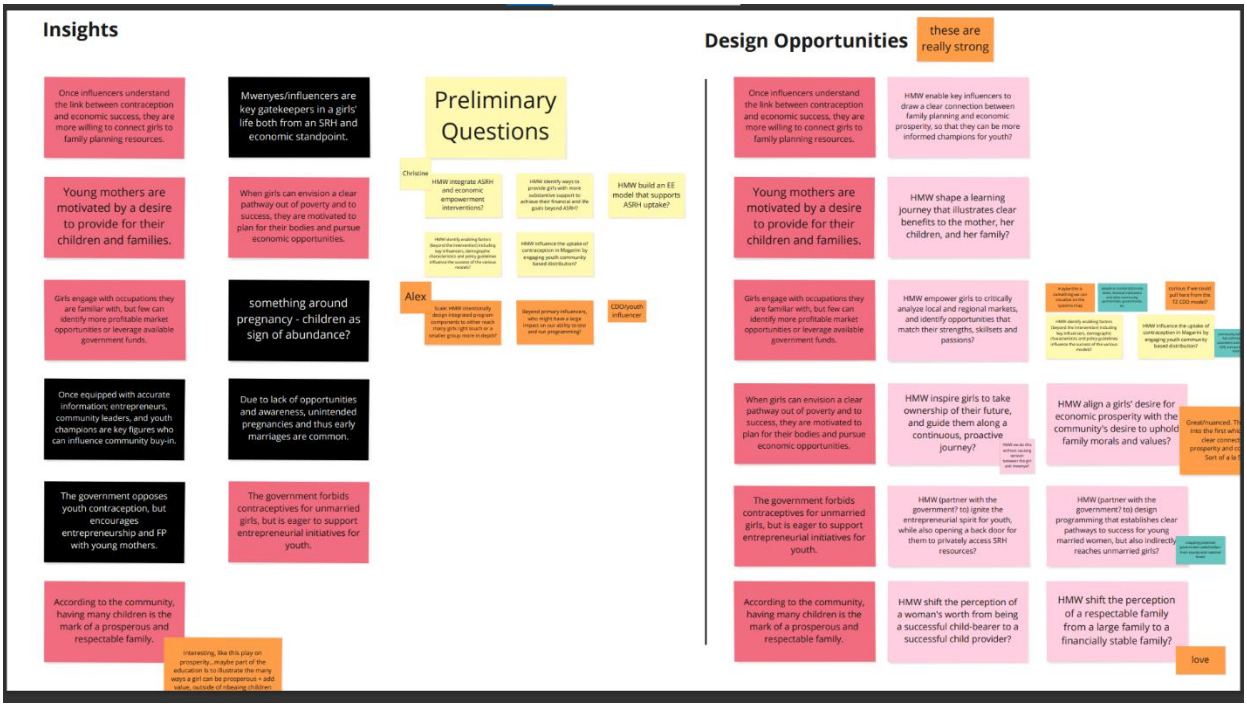
A robust HCD research & learning agenda was set up to entail *understanding, applying, and sharing what works and why*, to achieve the program's goals. This research & learning agenda centred on addressing critical gaps and building a knowledge base specifically around Maverick Next program in order to:

a. Strengthen engagement of adolescent girls' and their key influencers to improve the enabling environment for girls' agency and SRH decision-making
b. Strengthen vocational skills component & use partnerships to expand economic empowerment opportunities for young mothers
c. Support adolescent girls' access, uptake, and continuation of contraceptive method use, particularly girls who are hardest to reach
d. Work towards long-term sustainability by Identifying and addressing barriers to integration of the program within government health systems.

Through a set of key insights generated from PSI's **Adolescents 360 project (Binti Shupavu)** – *the world's leading program that brings together youth, public health and design thinking – that now shape the way we design adolescent and youth sexual and reproductive health programs across the world*, the design team learned that **the vocational skills component / EE component:**

1. Captures young women's interest and motivates them to engage with its SRH programming.
2. Plays a critical role in building community buy-in for young women's participation in the program and
3. Provides 'social cover' for young women to access SRH services.

Supported by Maverick*NEXT*, the HCD Design Team which composed of **IDEO.org and PS Kenya team,** ran an adaptation sprint in Kilifi to ascertain whether young women and their influencers expressed a desire for more substantial support when it comes to economic empowerment.



The key design opportunity was framed as; **How Might We (HMW)** build on the existing SRH model to provide more substantial economic empowerment support to young women while maintaining critical linkages to SRH services and considering sustainability at scale?

The HCD research and learning approach was based on a technical learning cycle that is centred on:

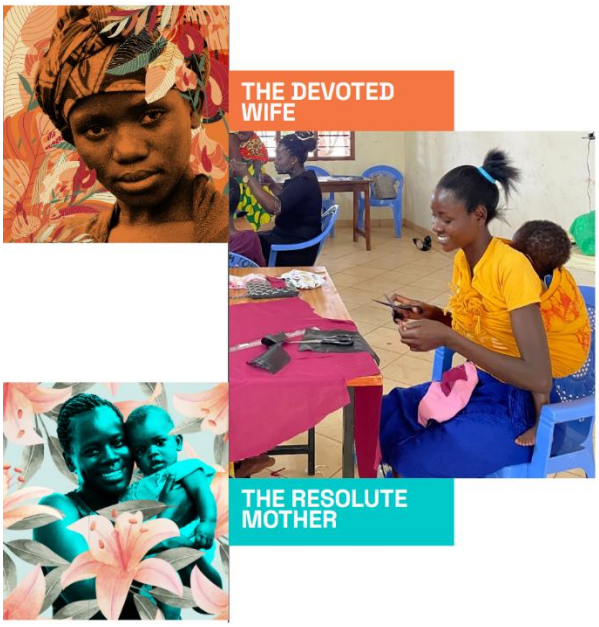
1. Deliberately designing programs with young mothers at the center in order to achieve lasting health impact-at-scale;
2. Using fit-for-purpose evidence to adapt and remain responsive to evolving contexts; and
3. Strategically disseminating results across the lifecycle to shape markets, influence policies, and shift funding to respond to consumer desires and therefore achieve sustainable health impact faster.

TARGET ARCHETYPE

Pendo, the target archetype, is a young mother aged between 15-24yrs who, until now, would not have been able to access income generation opportunities given their lower education levels, early pregnancy and other inherent challenges.

The focus is to serve Pendo, the hero of our story, our Archetype. She is at the center of the program's strategic plan: her disease burden, rights, family planning needs, health-seeking behavior and required solutions that **empower her to survive and thrive**.

Following Pendo's health-seeking needs, the goal is to **co-design solutions** based on the diverse needs affecting her and her children, and supporting markets and policy environments that are **Pendo-Centered**.



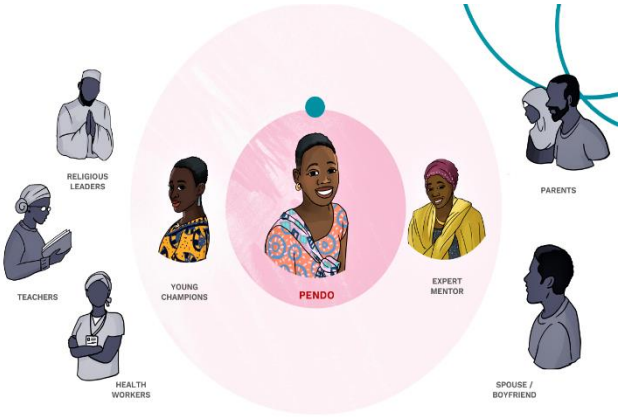
ARCHETYPE
PENDO

Young Woman - 15-24 years

Our target archetype from our preliminary research focus on the life of a **young mother** between the age of 15 - 24, **school dropout, married or unmarried.**

This artchetype contributes to the largest number of girls who are left behind when it comes to exposure and access to economic empowerment opportunities.

Gaining **empathy** ensured that we kept girls like Pendo at the center of all of our decision making, and it forced the program to seek empathy not only for her, but also for anybody in her **sphere of influence** e.g., family members, community health workers, etc.
It's crucial to design not just for young mothers, but also for the ecosystems surrounding them, so that the intervention can be sustainably championed and supported by her broader community.



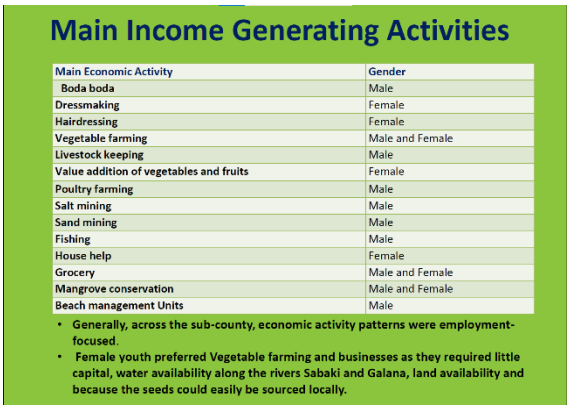
VALIDATED PROTOTYPES

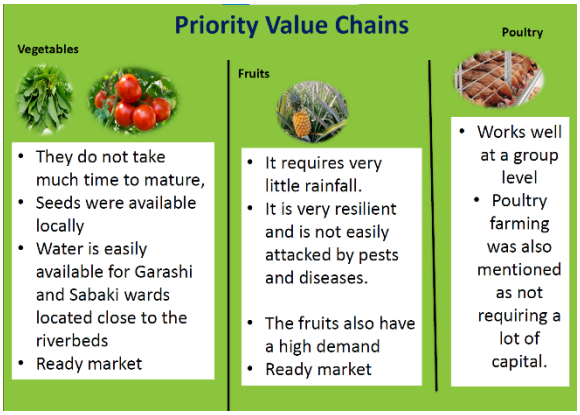
The Human-Centered Design approach was very exploratory; combining qualitative research practices from the fields of ethnography, and participatory action research (PAR) targeting young mothers (married or not married) in the subcounty of Magarini in Kilifi. Qualitative data was collected through the following techniques: Photo narratives, focus group discussions (FGDs), key informant interviews (KII), in-depth interviews (IDIs), and observation. This also included

interviewing other community members and experts in order to generate a diverse set of insights to inform the program's design.

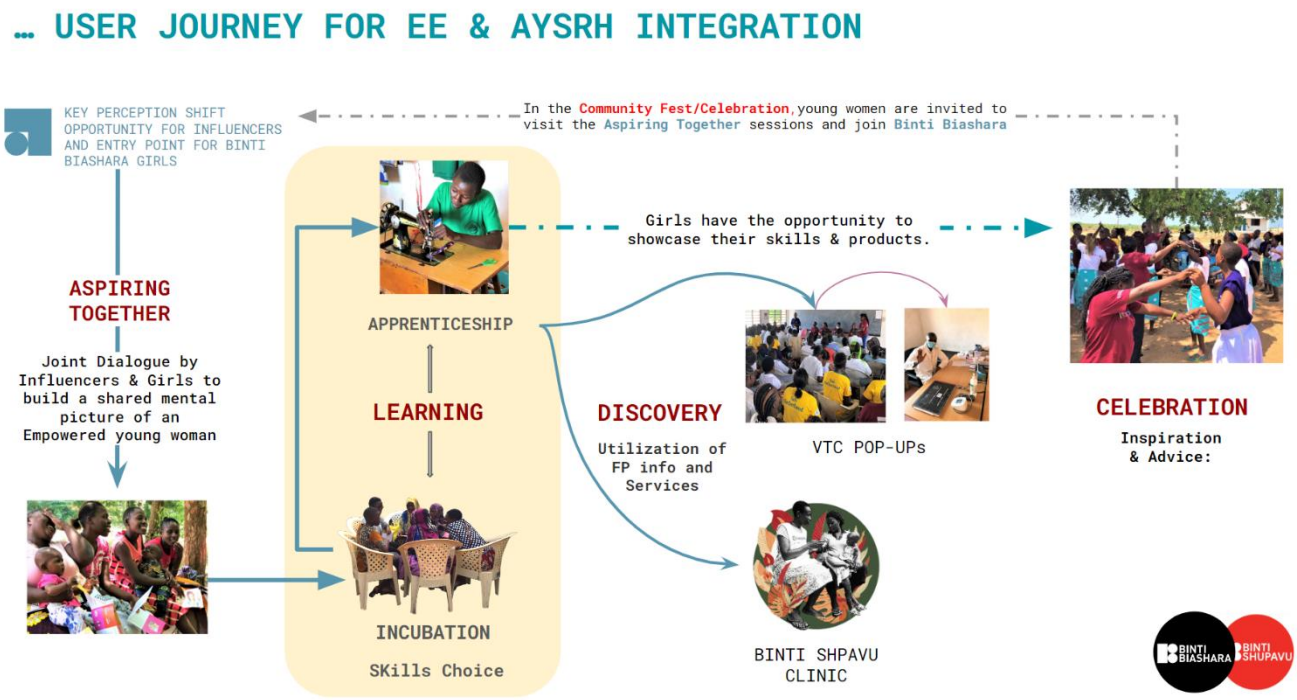
All of the existing data that was obtained from relevant programs in Kenya were also reviewed, namely PSI's Health Marketing and Communication program which has specifically targeted youth through the Kitu Nikuka-Chora programs, as well as through the Maverick Project Riziki in Kilifi, in order to identify barriers and facilitators to access to and use of contraception by young people alongside.

The review also explored economic factors that influence contraceptive access and decision-making thorough a **Formative assessment** that was conducted in collaboration with our livelihoods partner (ICL – I Choose Life) in order to uncover market opportunities for business/entrepreneurship building for 15–24-year-old in Kilifi, Magarini Subcounty.





After going through rigorous phases of **insight gathering** and **concept validation** exercises (Live prototyping), the program HCD design team narrowed into two wholesome approaches that encompass an **Institutional Model and a Community Based Model** with a user journey vividly illustrated in the figure below.



1. APSIPIRING TOGETHER:

Binti Biashara - Aspiring Together brings the topic of Economic Empowerment & AYSRH to the young women, mothers, husbands, and community leaders. These Influencers come together and will have the opportunity to hear stories from others as well as share their own journey of growth as the people who the young women rely for advice and support around entrepreneurship and contraceptive. Together, they dream and aspire together about who and how their community "Pendo" should be.

They agree on her main set of values and this "Pendo" acts as a mascot and role model throughout the rest of the program.

Using created assets, including the ***Who She Is, Fun Facts card game and the Smart Start booklet,*** discussions are held that demystify misconceptions and create better understanding on the relevance of contraception to a young mother's life journey.

Other than creating an avenue for the influencers to get correct information and learn from their common experiences, Aspiring Together session also aims to create a supportive environment for young women seeking ASRH knowledge and access. This is also an opportunity to scope potential mentors and interest in the program.

2. THE LEARNING PHASE:

This phase encompasses two sections: **Incubation and Apprenticeship:**

The first stage is **Incubation;** young mothers are exposed to various vocational skills using a *skills choice facilitation guide.* This activity allows them to become aware of a variety of skill sets that they could acquire and allows them rank their interests in order of priority.

The next stage is **Apprenticeship;** young mothers are enrolled to either a Vocational Training Centre (TVET) or linked to a Business Entrepreneur (CBM). The considerations on where to place the girls were in relation to the proximity of a girl's home i.e., to the nearest TVET or Community Based Mentor (1st priority being the proximity to a nearby TVET).

COMMUNITY BASED MODEL: In order to explore homegrown solutions that augment existing infrastructure and actualize the EE component of the program, mapping activities were carried out to onboard Community Based Mentors who have the interest of carrying out apprenticeship sessions in their business premises and partner with trained CHVs in holding ASRH sessions.

The program entered into partnership with the identified business entrepreneurs, sensitized them on expected SRH outcomes and how to handle our "Pendo", established a supportive structure to build their capacity in order to enable them absorb and effectively equip our young mothers with necessary skills.

THE INSTITUTIONAL MODEL: In collaboration with instructors and management of Vocational Training Centers, a unique partnership has been established resulting in a customized training program designed to suit the needs & lifestyle of our target archetype "Pendo" as follows:

Customized Curriculum;

- **Reduced Course Duration** – The institutions developed a course that runs for a reduced period of 12 weeks instead of the standard curriculum that is full of theory sessions and runs for a minimum period of 1½ years. (*18months*)

- **Practical Intensive** – The lessons were customized to be mainly practical skill sessions
- **Flexible timing** for lessons – The young mothers were allowed to start their lessons from 10am instead of the standard 7am classes expected of the other students. This flexibility accommodated the fact that the young mothers have the responsibility of carrying out household chores in the early mornings.
  In addition, their lessons were structured to be half-day sessions and thereafter they were allowed to stay within the institution to keep practicing what they have learned at their own will.
- **Restructured Cost** elements – The institutions agreed to reduce the tuition fees by 73% (from Ksh. 15,000 to Ksh. 4,000)
- **AYSRH** - trained Service providers and from linked health facilities were allowed to package and deliver AYSRH modules that were offered as supporting subjects the customized curriculum.
- Special considerations – The institutions allowed young mothers to attend classes without the standard uniform

3. DISCOVERY

The concept of discovery is where the program explores ideal opportunities where SRH messaging is intensified. The program witnessed an increase in the number of touch points where communication to young mothers about SRH was enabled. This aspect of **creating more opportunities for repeat messaging** is crucial in achieving significant behavior change in a shortened period of time.

We saw the first SRH touch point being at the **Aspiring together** sessions where both influencers and girls are brought together. Using created assets, including the *Who She Is, and the Smart Start* tools, discussions were held that demystified misconceptions and created better understanding on the relevance of contraception to a young mother's life journey.

In the Institution Based Model, the design team learned that there were existing bi-monthly **Health Talks** at the TVETs. These sessions were thereby enriched and packaged to have age-appropriate, scientifically accurate information consistent with the evolving capacities of young people and thus became a very effective platform to give access to information.

In conjunction with a health facility in the institution's proximity, the already existing guidance and canceling rooms were upgraded to meet the quality standards for health service provision.

This setup provided a much-needed **Safe Space** in which trained and youth friendly Service providers from linked health facilities conducted Opt-out session for girls within the Vocational Training Centers.

Taking health care and SRH services to all the girls at the institutes is advantageous as it minimizes missed opportunities for access & utilization of integrated SRH services.

In the Community Based Model, **ASRH Weekly Sessions** were held by the trained youth champions and CHVs all over the onboarded mentorship sites where the girls are invited to share their stories, discuss their concerns and discover their contraceptive options.

Monthly in-reaches and out-reaches were conducted by linked health facilities where all young mothers fitting the description of the target archetype, were mobilized to attend the ASRH sessions. The setup of these in-reach and out-reach activities was assimilated from and hence structured like the PSI's **Adolescents 360 project (Binti Shupavu)** Clinic sessions.

4. CELEBRATION

This is a **graduation ceremony** where young women are recognized for their achievements and completion of the program journey.

They are awarded certificates authenticated by the program director, training institute and the ministry of health.

Girls have the opportunity to showcase their products and have market experience.

Also, the Community receives accurate information on sexual and reproductive health and is inspired by entrepreneurs to create an enabling environment for girls' Economic Empowerment

BINTI BIASHARA LEARNINGS & OPPORTUNITIES

Impact

- Based on the impact you want to have, what is the right level of intervention?

- The linkages and introductions to vocational skills supported exposure and some AGYW will be proactive in pursuing options, (most will not due to inherent socio-economic challenges and hence calls for a next level intervention). If you want to have a transformational impact of supporting training, ongoing coaching, multiple interventions, this takes a good deal of resources, systems and commitment to ensuring it is impactful.

- Consider thinking through what is feasible, aligned with overall goals (e.g. learning about business opportunities, launching a business, maintaining a business?) and the outcomes of EE desired to adapt with these in mind.

Scale

- If looking at scalability, Binti Biashara EE components are time and resource intensive, particularly start-up inputs, CMB and TVET capacity building resources. These are also unlikely to be maintained during government transitions unless they are embedded into existing government scholarships and schemes available to the target audience.

- For scale, success of these inputs also requires follow up and support beyond the training and inputs. Without this and without structures in place, start-up funding is often used by families for consumption, at least in part, start-up kits are often sold for cash, either at the start or later when the business is not doing well, and TVET training can go unutilized.

- Consider how to make inputs more sustainable, e.g. starting businesses with existing assets or inputs from the family members. This allows AGYW to learn how to start with what they have and not be reliant on an NGO intervention for start-up.

Market Alignment with Training

- TVETs are a great training option and they can be difficult for scaling and impact due to the fact that:

    - Quality continues to be an issue

    - Access can be challenging for some communities

        - Young mothers and those with few resources often struggle to complete courses due to competing responsibilities or need significant support for transport, childcare, and domestic tasks support.

        - Courses offered by a TVET do not always align with market opportunities - how to overcome these barriers and what is the impact of the customized curriculum developed tested through live prototyping.

    - Community Based training is a great option. Need to explore alignment with market opportunities here as well AND be sure that the trainers have sufficient skills (or are trained on them) to train AGYW both in the soft skills and technical skills needed to be successful in the business trade being trained on.

    - Consider the Labor Market Assessment content and what sectors will provide sustainable and meaningful incomes for AGYW. Current Binti Biashara model seems to have traditional sectors being pursued that are often oversaturated in a community making sustainable income and consistent income challenging to obtain.

    - Note: Suggest digging deeper on amount and sustainability of contributions to family expenses. This is common to report at the beginning but is often short lived and/or contributions start to be done to family rather than reinvesting in the business which then leads to business decline

Entrepreneurship Skills

    - If looking for outcomes on entrepreneurship, consider the technical skills necessary for success in entrepreneurship and if these are feasible to be trained on through an existing government or NGO program that can partner with Binti Biashara.

    - What self-funding approaches can be explored and strengthen to enable girls to initiate and further their entrepreneurial aspirations.

Linkages

    - Financial Institutions:

        - Loans available for AGYW are often unavailable to AGYW directly or without collateral and unavailable to start ups

        - If families apply for the loan on behalf of the AGYW, in BRAC's experience it is rarely used for the business but goes to consumption

- Other linkages: if want to have impact think about coaching and support that will need to go into support AGYW in following through on linkages

- May be also helpful to think about where the clinics partnership comes in regarding linkages - how are they engaged if at all? Is there any alignment with their work and supporting linkage follow up?

Mentors

- This mentor document has been shared with teams in Nigeria and Ethiopia previously - may be a helpful resource in considering what it may take to successfully train and support mentors in EE additions to BB:
    - A360 Mentor Resources

Key Questions captured:

- 1. What is our objective/what we would like to accomplish with integrating to some degree the EE component/aspects on to any SRH focuses program?
- 2. The institutions model might have its own challenges, ensuring we have clarity on them - cost, girls participation (time), courses available, quality of content
- 3. How can the capital/seed angle be more organic? more sustainable
- 4. More inputs on the business / technical skills- what other skills are needed to make it more successful? accounting, entrepreneurship, marketing etc.

Results Framework

- Work backwards from level of intervention - to what extent do we think we'll see outcomes?
- List of possibilities / indicators for human capital development (financial literacy, self-efficacy, savings, etc.);
  There is need to put together a table that delineates different interventions and the level of change expected to be seen (e.g. MMA - 3 different journeys - e.g. - walk ins vs. EE full intervention)
    - Look at stop light indicators with a critical lens to understand what we want to accomplish and then segment the level of support from that; any outcomes missing?

Literature Review of documents

- https://psiorg.sharepoint.com/:p:/r/sites/us_a360/_layouts/15/Doc.aspx?sourcedoc=%7Bf2635ec2-863c-4719-908a-4cf87f92fee0%7D&action=default&cid=d1632936-3d8e-493d-9398-dc5b3005e537

- Indicators: Perseverance/resilience or proactive/follow through
    - PI training - personal initiative for entrepreneurs

- Purpose of including MDPI? (Request from CIFF)

- Government Institutionalization and support - great inquiries on how this will look from a quality perspective and what is needed to maintain outcomes (WHO - Nine Steps to Guide)

MONITORING AND EVALUATION RESULTS

PROTO-TYPE and PILOT PHASE: The prototype phase was conducted between March to May 2022, running for 12 weeks while the pilot phase was conducted between June to July 2022, running for 8 weeks. During this phase: the following results were realized.

The project worked with four TIVETS and 99 community-based mentors transforming the lives of 489 young mothers. 58 went through the TIVETs while 431 were through the community-based mentors.

60 CHVs, 30 Service Providers and 40 Youth Champions were engaged.

33 in reaches, 24 outreaches and 1 pop up activity were conducted where 1197 women and girls received FP services, out of this 69.9% were aged 15-24 years. 32% of the girls were first time adopters and 68% were continuing users. 50% of the girls served were older girls aged 20-24 years while 30% were 25+ years older.

40 youth champions served 3,627 girls. From this 46.6% were counselled on FP, 26.1% were issued with condoms, 9.6 received OCPs and 12.6% were referred.

39 aspiring sessions were held in the community reaching 877 people, out of which 86.7% were adolescents girls aged 15-24 years and 10.9% were influencers.

Of all the girls reached during aspiring together sessions, 54% of the girls were married and 97% of girls had at least one child.

Quantitative Results

The qualitative assessments were conducted at the beginning and end of the pilot phase. The same participants interviewed at the beginning were also interviewed at the end and had to give verbal consent before participating in the study. Analysis was done using excel and the results were disseminated both internally and externally on 26th and 30th of August respectively.

Demographic characteristics:

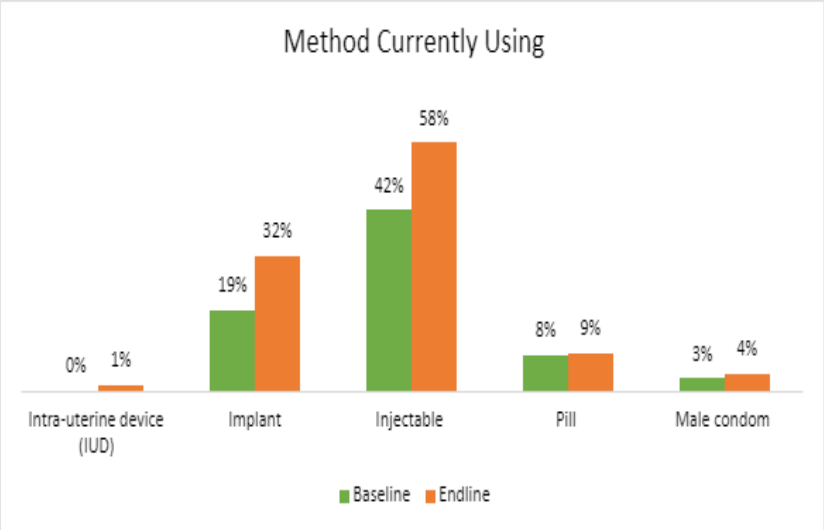
All three wards were equally represented in the survey. Adu had 33.53%, Marafa 34.10% and Gongoni 32.37%. 33% were aged between 15-19 years while the rest were aged 20-24 years. At the time the girls were enrolled in Binti Biashara project, all of them were not in school with 82% reporting to have dropped at primary school level, 15% at secondary school level while 3% had never gone to school. Majority were Christian (96%), and 62% reported to have given birth with at least one child. More than half (55%) were married at the time.

Comparison Between Baseline and Endline on Key Indicators:

Generally, there was improvement among the girls who were enrolled in the program. At the end, all reported having heard about ways to avoid/stop pregnancy, 23% more used a method to delay/stop pregnancy, 7 % more received AYSRH services while 13% increase of those receiving services from health care provider. These changes are shown in the table below.

	Baseline	**Endline**
Ever heard ways to delay/avoid pregnancy	**92%**	**100%**
Used a method before to delay/avoid pregnancy	**61%**	**84%**
Received AYSRH recently	**61%**	**68%**
Received services from health care provider	**86%**	**99%**

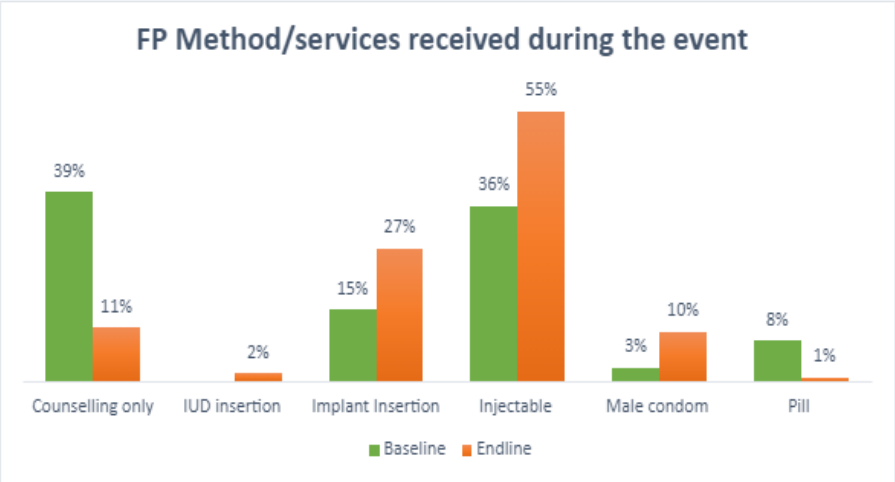
Method currently being used



At the point when the girls were exiting the program, most had shifted to the long-term method as indicated in the figure. Those using implant increased by 13% while those using injectable increased by 16%. This was also because some girls who joined the program without the method had now taken up a method.

Also, during the AYSRH services received during the program, there was an increase in the number of girls receiving family planning methods and specifically from health care providers. During the baseline, most girls reported only receiving counselling, but towards the end of the project, there was an increase in the girls taking up methods. Implant increased from 15% to 27%, while Injectables increased from 36% to 55%. The number of girls taking counselling only and pills reduced from 39% to 11% and 8%to 1% respectively. These is indicated on the figure below.

FP Services during events

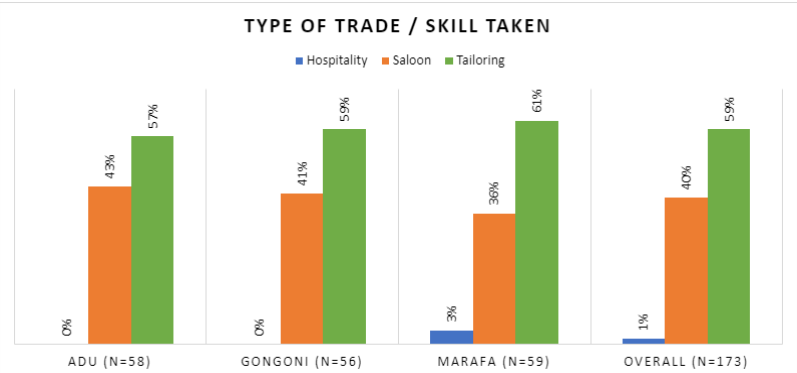


Also, during the AYSRH events, services received in the course of the program, there was an increase in the number of girls receiving FP methods and specifically from health care providers. During the baseline, most girls reported only receiving counselling, but towards the end of the project, there was an increase in the girls taking up methods. Implant increased from 15% to 27%, while Injectables increased from 36% to 55%. The number of girls taking counselling only and pills reduced from 39% to 11% and 8%to 1% respectively. These are indicated in the figure below.

Contraceptive use Decision

34% of girls reported they were now empowered to make up decision independently on the use of contraception, while 64% reported they were able to jointly make the decision with their husbands/partners. However, there are still influencers within the girls' cycles, among them finds, partners and mothers that would influence the uptake and choice of method by the girls.

Type of skills/trades preferred

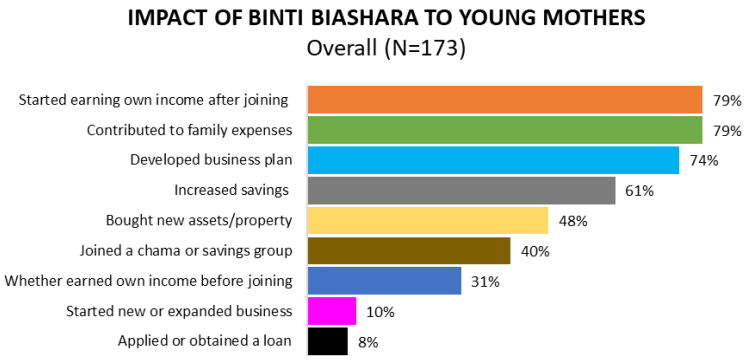


There were several skills and trades that were available for girls to pick from during the aspiring together sessions. There were 2 major categories of skills for choice; traditional skills and modern skills. Young mothers were brought together with their influencers, community-

based mentos, and instructors from Vocational Training Centers (VTC) during incubation sessions. Among the traditional skills that were presented to the young mothers were tailoring, hairdressing, jewelry making, caterer and cooking, Basket making, Tye Dye, and batik, Soap making, and shoe making. Those that were the most preferred skills under traditional skills were tailoring/dressmaking, hairdressing, and catering were taken up by most girls as shown below:

Young mothers were also subjected to non-traditional methods such as electronics wizard, bricklayer, mechanics, makeup artist, solar panel installer, carpentry, sanitary pads maker, and mobile phones repair, however, most of the young mothers did not prefer those skills but for some who picked, they did not manage to get them given that they were not available at their locality

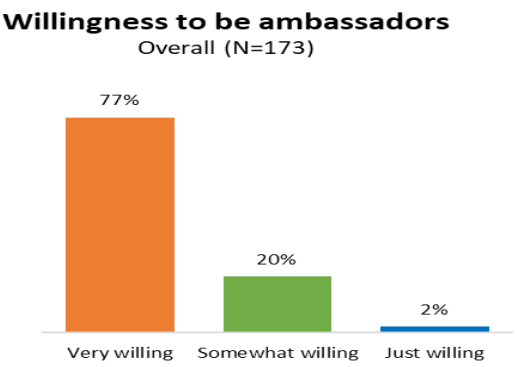
Impact of Binti Biashara on young mothers:



There was a 48% increase of girls who said they are now earning some income since joining BB with 79% contributing to family income. Other positive changes observed are the ability to join saving groups and well add do savings.

Project satisfaction

97% reported that they were satisfied or very satisfied with the quality of the training given through the CBM. 99% of participants were satisfied with the program and said that they were optimistic that the program will change the lives of young mothers in the community in SRH & EE.



77% of the girls said they were very willing to become an ambassador to other young women in their community.

Qualitative Results

A feasibility study was conducted at the end of the pilot phase to determine the feasibility of blending an economic strengthening component onto Binti Shupavu. This was a cross-sectional method that employed qualitative design using key informant interviews (KIIs), in-depth interviews (IDIs) and focus group discussions (FGDs). This was to give a snapshot of the key themes related to implementation enablers, barriers and facilitators and surface recommendations to the project.

Four focus group discussions and 12 in-depth and 13 informant interviews were conducted covering 70 participants (48 AGYW, 13 Informants, 9 husbands/partners). During the interviews, sessions were audio-recorded. The analysis was done using NVIVO software where codebooks were developed using the FRAME-IT* (Feasibility, Reach-out, Acceptability, Maintenance, Efficacy, Implementation, Tailorability) framework (Gonot-Schoupinsky & Garip, G. (2019), and documenting of transcribed verbatim. The process employed a deductive analytic approach.

Feasibility: Many young people in Kilifi are sexually active with the median age of first sexual intercourse reported to be 18.4 years. Despite this, access to and use of modern methods of contraception in the county is low. Clent exit study conducted indicated that 62% of the girls enrolled in the program had at least one child, 82% were primary level school dropouts, while 15% dropped at secondary school level and 3% of the girls had never gone to school. This was good ground to conduct an economic empowerment project, as well as improve awareness and access to contraceptives among the adolescents' girls. Availability of TIVETs institutions as well and Community Based Mentors, as well us stocked health facilities within Magharini subcounty made the implementation of this program successful. 431 girls went through the CBM while 58 went through the TIVETs.

From the FGD sessions, it came out that girls and their partners know about SRH services and where to access them. The following verbatim were reported from an FGD sessions

- "When i began, I did not know about family planning but now I do", Respondent 1 FGD Marafa.
- "After them teaching and explaining to us about family planning and its benefits that is what made me start using", Respondent 2 FGD Msumari

Reach-out: There were also diverse channels that were used to reach girls (mainly CHVs but also village elders, Neighbours, church, relatives and friends) as they mentioned during the FGDs. From the quantitative analysis, 77% knew about BB from CHVs, while 20% heard from community leader. It was clear that the project was reaching the right participants and those who needed the intervention as mentioned by one of the participants during the FGDs ("When we heard about this project, it was registering 15- to 24-year-old girls who gave birth while still living with their parents or who don’t have a source of income", Respondent FGD Kamale). In one of the FGD, girls were reporting access to FP information, counselling and services. 4 out of 9 girls started using FP after being in the program (5 were using already)

Acceptability: It came out clearly that there was wide acceptability by the target population group. Several comments related to the same coming from the key informants are:

- Girls see it as a solution to their persistent problems
- Excited to be empowered with skills and to return to school
- Girls have high expectations
- Those who benefit are willing to cascade training to others

- More girls are yearning to join after witnessing success from their peers

Maintenance: The project was done in collaboration with local actors, that is County (Kilifi) and Sub County (Magharini) teams from the ministry of education, health and social service department. That way, the team can duplicate the same strategies to empower the local communities. Also, most of the girls preferred skill sets that were locally available and offered by the 99 community-based mentors selected who are accessible at the community level, this will help them to further their skills sets, if need be, even beyond the project end. Also from the quantitative study, 74% of the girls reported that they started earning their own income since they joined the program, thus having been empowered economically even to contribute to their family expenses. Some CBMs also required the girls also to be able to buy some materials, so for those earning some income, will help them to buy required materials and continue with the mentorship with CBMs.

One of the girl from the FGDs also mentioned, "I knew that once I have trained in would also train my friends", Respondent 2 FGD Msumari. This is an indication of the girls themselves being able to scale up and encouraging their peers to take up a skill and empower themselves economically.

Efficacy: Girls and their partners reported from the FGDs that they now know about SRH services and where to access them, and this was confirmed from the quantitative assessments where all the girls said they had heard ways to delay/avoid pregnancy by the end of the sessions, 58% were already using a method and 99% getting services from a health provider. 90% of young mothers understand the value of economic empowerment while 84% were able to link between (contraceptives), financial (economic empowerment) and social life (relationships).

From the FGDs with the girls and husbands of the girls that were undergoing the interventions, positive feedback about girls economic empowerment as well and self-efficacy was reported as shown below:

- Started earning their own money ("She is now earning her own money "Husband Marafa FGD)
- Now able to save money
- Contribution to domestic expenditure
- Using the products for own and domestic purposes: "I did not have any clothes to wear but was able to knit my own clothes. Now I can be seen and respected in the community", Respondent 2 FGD Marafa
- Learning vocational and life skills: "I did not know how to bake a cake, cook pilau or chapati but right now I know how to cook. I sell some food items and get money to fund my needs", Respondent 7 FGD Kadzuhoni.
- Gained entrepreneurship skills and confidence to be able to start a business
- Trained in customer relations
- Improved communication: "I am no longer afraid to communicate with my husband because I feel free", Respondent 6 FGD Kadzuhoni

- Gained essential life skills e.g., cooking
- Understand how to manage their time
- Established new relationships and enhancing girls' social capital: "Used to have no friends but now am building relationships with new friends", Respondent 10 FGD Marafa
- Improved self-esteem and improved perception of respect from the community
- Empowered to be self-reliant
- Transformed lives: "Binti Biashara is good because it changes someone from where they were and takes them somewhere else. The place I was I don't want to go back to because I couldn't save but right now I can" Respondent 1 FGD Kadzuhoni.

At the end of the program, 79% of girls said they are now earning some income since joining BB as well as contributing to their family income.

Implementation: During the implementation process, some positive factors contributed to the girls learning and completing the required sessions for the different skill sets. Part of the contributing factors throughout the process were mentioned by the FGD and KII respondents as shown below:

- The facilitators were patient, confident and skilled: "The trainer was patient with me and repeated until i learnt", Respondent 1 FGD Marafa
- Participants given adequate opportunity to practice skills: "They were good because you were given tasks and assisted to do it, like plaiting you would be asked to repeat until you get it", Respondent 2 FGD Msumari
- Encouragement from trainers
- Provided with branded merchandise
- Availability of wide range FP methods during in-reach and outreach services
- Support from parents, husbands/ partners and Neighbours

Tailorability: Different skill sets were provided to the girls for them to choose preferred trade. The girls demonstrated this from their feedback as shown below:

- We were given the opportunity to choose preferable skills
- Given a chance to showcase skills: "I displayed my saloon skills then for those sewing they displayed their clothes", Respondent 10 FGD Msumari
- Individual motivation – driven by need and anticipated outcomes: "My goal was to get skills and rely on myself to provide for myself and my children", Respondent 4 FGD Kadzuhoni.
- Girls' choice of course is influenced by their peers and what is available, marketable

Unexpected Results

Friends are key influencers on the choice of contraception among adolescents' girls. 25% of the girls said they had friends who were against them taking contraceptives.

From the qualitative assessments during the FGDs, one participant reported that there were community members who had negative perceptions about the program and perceived it as cult as was reported "Some are not happy saying that it is a devil's cult", Respondent 2 FGD Msumari

LESSONS LEARNED, RECOMMENDATIONS, AND INNOVATIONS

The duration of 2-3 months was not enough for the girls to master trade competencies, thus there is need to Increase course duration for better engagement (6-12 months). This should also consider incubation period for the girls to start businesses and market their skills

All the girls joining were not working at the time and were not in position to buy materials. There is a need to provide basic equipment and training materials so that learning can begin as planned.

To reduce the long distances that girls must walk, it's recommended to get mentors who are operating near where participants live.

To maximize the limited time, there is also needed to examine the frequency of sessions e.g., five times per week

Expand the portfolio courses available by exploring more choice and skills since there are girls who wanted to pursue different skill sets, for example IT, plumbing etc. These can also be explored through the TVETS institutions available.

CHALLENGES

Some girls had to travel long distances to attend sessions, affecting their timings allocated for the trade learnings

Since most of the girls were already married and with children, Findings someone to take over their domestic responsibilities as well us take care of their children was a major challenge and sometimes resulted to absenteeism when they needed to attend to their other responsibilities like attending to a sick child.

Some preferred skills were not available and thus girls had to take whatever was available within their localities. Examples of such skills include IT, plumbing, electronics, mechanics, hospitality in some wards among others.

The program took place in three months; thus, the short duration was inadequate to gain competency of some trade

STRATEGIC PROJECT PARTNERS, LEVERAGE & GOVERNMENT INTERGRATION

OTHER SOURCES OF PROJECT SUPPORT

PROJECT LEGACY & NEXT STEPS

PROJECT OUTPUT DOCUMENTS / DELIVERABLES

Level	Objective description	Indicators	Achievements	Data Source
Goal	**Increased access and utilization of contraception and improved livelihoods opportunities for adolescents and youth in Magarini Sub County**			
Outcome 1	To increase utilization of contraception by adolescents and youth ages 15-24 years in Magarini sub county.			
Intermediate outcome 1.1	**Adolescents have increased self-efficacy around SRH**	**% of girls reached by the project who report confidence in speaking to a provider about their fertility preferences.**	88%	CEI
Output 1.1.1	Improved availability of AYSRH information.	Number of adolescents and youth 15-24 years reached with messaging on contraception	5179	Project reports
Activity1.1.1.1	Build capacity of community health volunteers and youth champions to disseminate accurate information at the community on contraception to create demand.	Number of community health workers (CHVs/youth Champions/CBDs) sensitized of on demand creation among adolescents and youth.	40	Project Reports
Intermediate outcome 1.2	**Adolescent girls have greater access to quality AYSRH**	**% of girls reached by the project report that they were treated with dignity and**	94%	CEI

	information & services.	**respect during their experience of care.**		
		% of girls reached by the project who receive contraceptive counseling who report no provider bias.	97%	CEI
Output 1.2.1	Improved quality of AYSRH services	Number of health facilities with trained providers (AYSRH)	15	Project reports
Activity 1.2.1.1	Train / provide mentorship to health care providers on AYSRH.	Number of health providers trained on youth friendly/ inclusive services (YFS).	25	
Activity 1.2.1.2	Provide quality assurance support to health service providers.	Number of supportive supervision visits conducted at health facilities focusing on quality assurance.	6	
Output 1.2.2	Improved access to AYSRH services	Number adolescents & youth accessing AYSRH services.	68%	CEI
Activity 1.2.2.1	Support community-based distribution (CBD) of FP services and products targeting adolescents and youth.	Number of CBDs providing FP services to adolescents & youth.	18	Project reports
Intermediate outcome 1.3	**AYSRH-EE integration leads to increased Intent by adolescent girls & youth to use SRH services**	**% of girls reached by the project who say they intend to use contraception either now or at some point in the future.**	29%	
Output 1.3.1	Viable prototypes for	At least one viable EE-AYSRH prototype	2 Prototypes	Project report

	integration of economic empowerment (EE) and AYSRH tested	completes testing cycle		
Activity 1.3.1.1	Engage Magarini sub-county adolescents & sub county team in developing prototypes for economic empowerment – SRH integration.	Number of prototypes developed jointly with the target audience and stakeholders.	2 Prototypes	Project report
Activity 1.3.1.2	Test the prototypes	Number of prototypes starting testing process	3 Prototypes	
Output 1.3.2	Documented learning from EE-AYSRH integration programming	Number and type of Maverick project knowledge products shared externally to Maverick project (with other PSI projects or with partners)	3	1. Design Playbook 2. Milestone Share-out Document 3. Project Report
Activity 1.3.2.1	Documentation, packaging, and dissemination of Maverick learnings / knowledge products.	Number and type of Maverick project knowledge products developed	0	1.Program Final Playbook 2. Program Assets Inventory 3. Project Report

IMAGES, ICONS AND VISUAL ASSETS


CHEWs and Super CHVs Training
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Binti Biashara Kilifi County Dissemination meeting


Binti Biashara Kilifi County Dissemination meeting


Binti Biashara Kilifi County Dissemination meeting