GENDER

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Nairobi Youth Respondent-Driven Sampling Survey Follow-up and Gender/COVID-19 Study: Final Report

Version 1, February 2022

PMA|GENDER
PERFORMANCE MONITORING FOR ACTION

ICRH Kenya
INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH

KENYATTA UNIVERSITY

JOHNS HOPKINS
BLOOMBERG SCHOOL of PUBLIC HEALTH

Bill & Melinda Gates Institute for Population and Reproductive Health

Contents

Lists of Tables and Figures

Lists of Acronyms

AY	Adolescents and youth
FGD	Focus group discussion
GBV	Gender-based violence
ICRHK	International Centre for Reproductive Health Kenya
IDI	In-depth interview
IPV	Intimate partner violence
KII	Key informant interview
LARC	Long-active reversible contraceptives
MHM	Menstrual hygiene management
PMA	Performance Monitoring for Action
RDS	Respondent-driven sampling
SRH	Sexual and reproductive health
YRDSS	Youth Respondent-Driven Sampling Survey

Acknowledgements

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The team at ICRHK was led by Dr. Peter Gichangi, PI-PMA Kenya, and Mary Thiongo, Project Director. The team included Agnes Rinyiru, Peter Kimani Kibandi, Anthony Mwangi, and Joseph Okore. Resident enumerators included: Wilkister Ahinga, Mary Aketch, Christine Aluoch, Esther Atellah, Mourine Imali, Marion Kamuyu, Nancy Kayago, Mary Kibe, Harriet Murugi, Catherine Nzioka, Maureen Mwangi, Wangeci, and Zipporah Zakhasia. Qualitative research assistants included: Hannah Muthama, Grace Munyatta, Hannah Mwaniki, Grace Nthunya.

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Executive Summary

Infectious disease outbreaks like COVID-19 and their mitigation measures can exacerbate underlying gender disparities, particularly among adolescents and young adults in densely populated urban settings. An existing cohort of youth ages 16-26 in Nairobi, Kenya, sampled in 2019 using respondent-driven sampling (RDS) methodology, completed phone-based surveys in August-October 2020 (n=1217) and April-May 2021 (n=1177), supplemented by virtual focus group discussions and interviews with youth and stakeholders, to examine health, economic, social, and safety experiences during COVID-19, and gender disparities therein.

Youth engagement and participation was embedded in all phases, from study preparatory activities through results dissemination. Strategic youth engagement began prior to 2019 baseline survey implementation, with formative research to inform RDS implementation and survey instruments and continued through participation in dissemination activities in 2021.

For more information about PMA Gender, please visit the PMA Gender homepage.

Summary of Key Results

	Key Results	Implications
COVID-19	• COVID-19 related concern and risk perception is high overall, modest gender difference favors young women • Youth were mixed on their level of concern for COVID-19 transmission • Significant barriers discussed to preventative health behaviors, including social and financial barriers • Anticipated stigma associated with COVID-19 was high • Expected vaccine uptake among youth was low	• Campaigns that target young people through social media and where they gather, such as schools, workplaces, churches, and social and sports clubs are essential to reinforcing preventive behaviors • Youth represent a critical population for overcoming COVID-19-related stigma and ensuring trust to support full vaccine uptake as it becomes available
Sexual and reproductive health	• Contraceptive disruptions common, particularly for coital-dependent methods • Fear of infection was the dominant barrier • Menstrual hygiene barriers are primarily financial	• Sustained needs for accessible, affordable contraception and menstrual hygiene products • Impact on unintended/early pregnancy unclear in that time with partners varies widely
Mental health & social support	• ~ 1 in 4 report symptoms consistent with depression • Confluence of economic and social hardship • Despite challenges, social support is high for both young men and women, speaking to resilience among youth	• Recovery efforts should address mental health impact, sustainable solutions • Social support can be harnessed for recovery efforts
Economic & educational impact	• Universal impact, though disproportionately affecting young women is severity • Time use differences show young men engaging in income generation; young women in caregiver/household roles • Young women's dependence on transactional partnerships increased • Young women faced greater economic barriers to returning to school	• Potential for sustained economic threats for this generation • Risk that gendered economic disparities could widen • Need to prioritize youth economic recovery, particularly young women
Mobility, privacy & access to technology	• Increased time at home to youth and their family members • Young women face greater privacy challenges & gaps in technology access	• Gender differences in privacy challenges may reflect underlying norms • Support and safe spaces for accessing services are a priority, especially for young women
Safety & violence	• Young men's risk centers on police violence • Young women face sustained risk for partner violence; sexual violence was primarily from partners	• Compliance efforts for public health measures must uphold human rights • Sustained needs for GBV prevention, response and survivor support

About PMA

PMA is implemented by the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health and Jhpiego. PMA supports regular low-cost, rapid turnaround, nationally representative surveys using mobile technology to gather, analyze and disseminate health information at both household and facility levels. The Youth Respondent-Driven Sampling Surveys are part of a separate project within PMA and were conducted in three urban centers: Abidjan, Côte d'Ivoire, Nairobi, Kenya, and Lagos, Nigeria.

About ICRHK

ICRHK is an independent, non-governmental organization (NGO) established in the year 2000. ICRH Kenya is affiliated to the ICRH global group, with independent country offices in Belgium and Mozambique. ICRHK has staff experienced in program design and implementation, and field teams that mount large-scale community interventions and behavior change in high-risk groups and measurement programs. There is a multidisciplinary collaboration between the research, clinical teams and the social scientists, and interventions are based on the best available scientific evidence and critically monitored by the scientists. Both the research and the interventions are always embedded in a dialogue with the communities concerned. Over the last 21 years, ICRHK has partnered with various organizations to implement high-quality sexual and reproductive health (SRH) programs.

About Kenyatta University Women's Economic Empowerment Hub

The Kenyatta University (KU) Women's Economic Empowerment Hub (WEE Hub) was established in 2020, building on the success of the KU Center of Gender Equity and Empowerment. The KU WEE Hub is an interdisciplinary initiative that convenes scholars and practitioners to advance women's economic empowerment in Kenya and the region, through applied scholarship and translation to practice and policy. The KU WEE Hub aims to use credible evidence to shape policy, program, intervention and advocacy efforts to advance Kenyan women in all economic spheres. The Hub's research portfolio addresses the interface of economic empowerment and gender-based violence, including during the COVID-19 pandemic.

Background

The COVID-19 pandemic has had profound implications for youth and young adults in Nairobi. Like so many emergencies, the COVID-19 pandemic is far from gender neutral. It underscores social and healthcare inequities within and across nations. Emergencies like infectious disease outbreaks can exacerbate underlying gender disparities in health, social and economic systems (Davies & Bennett 2016; Wenham et al. 2020a; Wenham et al. 2020b; WHO 2007). Sex-disaggregated data reveals a differential mortality burden to men, yet the outbreak's impact on survivors is differentially experienced by women, particularly those working at the lowest rungs of the informal labor sector and for whom educational attainment is already tenuous. For women and girls, infection containment measures can impart unique mobility barriers and economic risk when faced with difficult tradeoffs between protective behavior and economic stability. Differential social roles that emphasize household and care-taking tasks for women can pose additional pressures in the face of economic fallout and can elevate risk for infection exposure (WHO 2007). The economic fallout of the outbreak is already showing signs of differential gender impact. Disruptions to schooling and access to both formal and informal labor are critical to monitor and may play out along gender lines (Wenham et al. 2020a). Moreover, protracted economic disruption, restriction to the home, and social isolation can enable violence and coercion that represent rights violations in and of themselves, and continue to undermine economic empowerment. These issues may be exacerbated for youth and young adults given their developmental stage and the social pressure to conceal relationships and sexual activity, particularly for young women. Moreover, concern exists that low-risk perception for infection and transmission among youth can undermine their engagement in preventive measures. Given gender disparities in other aspects of preventive measures, it is important to explore gender gaps and their determinants in behavioral COVID-19 prevention.

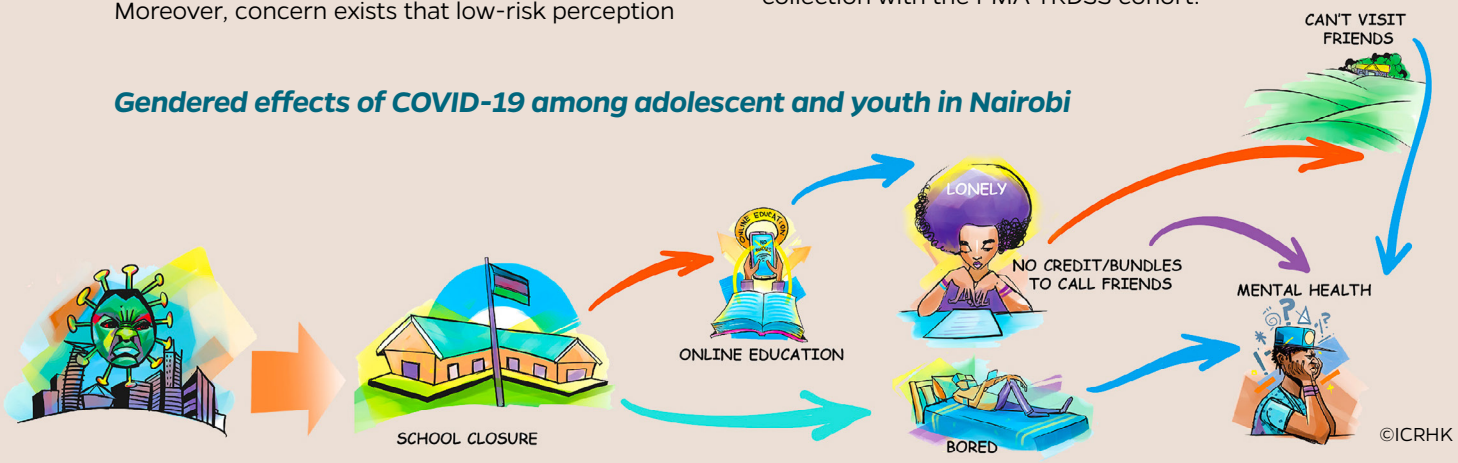
The Youth Respondent-Driven Sampling Survey (YRDSS) was initially launched in 2019 with the aims of measuring contraceptive method awareness and use among young women and men in Nairobi County, Kenya and understanding the sources of and consumption patterns of contraceptive methods among this population. From June to August 2019, PMA Agile and ICRHK conducted this survey using respondent-driven sampling (RDS), a chain-based recruitment method, given feasibility concerns for household- and clinic-based sampling for this study population.

Follow-up data collection with this youth cohort took place in 2020 and 2021 and the scope of the research broadened to capture the experiences of young people during the COVID-19 pandemic, allowing a better understanding of the gendered dimensions of health, safety, and economic stability among this specific sub-population. The two overarching objectives of the follow-up study (YRDS Follow-up & Gender/COVID-19 Study) were to:

1. Characterize changes in contraceptive use and determinants since the 2019 survey, and
2. Characterize gendered dimensions of social, economic, and safety impact of the COVID-19 outbreak.

The following report highlights key findings from the 2020 and 2021 rounds of data collection with the PMA YRDSS cohort.

Gendered effects of COVID-19 among adolescent and youth in Nairobi



Study Timeline

2019

- **JUNE-AUGUST** — Baseline data collection (Round 1)
- **OCTOBER** — Nairobi dissemination event

2020

- **AUGUST-OCTOBER** — Phone follow-up surveys (Round 2)
- **AUGUST** — Focus group discussions with youth & youth-serving stakeholders; Key informant interviews
- **OCTOBER** — In-depth interviews with youth
- **NOVEMBER** — Data validation workshop & Nairobi dissemination event
- **NOVEMBER-DECEMBER** — Text message mini-survey

2021

- **JANUARY-MARCH** — Text message mini-survey (continued)
- **APRIL-MAY** — Phone follow-up surveys (Round 3)
- **MAY-JUNE** — In-depth interviews with youth
- **SEPTEMBER** — Inter-organization symposium

Methodology

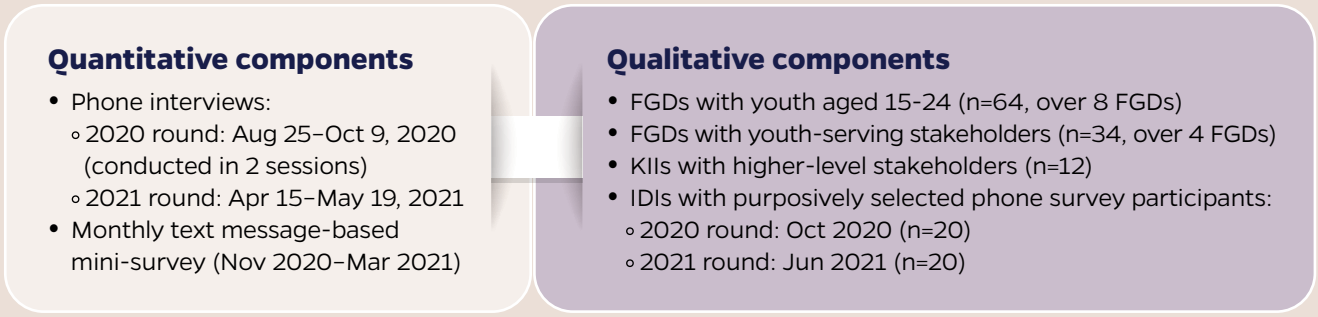
YRDSS Baseline Recruitment (2019)

The youth cohort was recruited in June-August 2019 using respondent-driven sampling (RDS), a chain-based recruitment method that relies on peer-to-peer coupon distribution for study enrollment. Eligible youth were age 15-24 years, unmarried, and residing in Nairobi County for at least one year prior to enrollment. In 2019, 1,357 participants were recruited, of whom 95% (1293/1357) completed the survey and provided consent to be recontacted and a contact phone number. Additional details about the 2019 survey can be found online in the Nairobi YRDSS Final Report (ICRHK & PMA 2020).

YRDS Follow-up & Gender/COVID-19 Study Design (2020 & 2021)

The YRDS Follow-up & Gender/COVID-19 Study utilized a mixed-methods design (Figure 1). In August 2020, participants who consented to be recontacted and provided a contact phone number at baseline (2019) were contacted for a second round of interviews. The baseline cohort was recontacted and surveyed in August-October 2020 and in April-May 2021. The 2020 survey was conducted in two distinct sessions to minimize participant burden; there was minimal attrition between survey sessions (Figure 2). At the 2020 survey, participants were also invited to participate in a monthly text message-based mini-survey to capture key indicators between survey rounds. In addition, qualitative data was collected at both time points, with focus group discussions (FGDs), key informant interviews (KIIs), and in-depth interviews (IDIs) conducted in 2020, and with IDIs conducted in 2021.

Figure 1. YRDS Follow-up & Gender/COVID-19 Study Components



Due to the COVID-19 pandemic, all study activities were conducted remotely. All procedures were approved by the Ethics Review Committee at Kenyatta National Hospital/University of Nairobi and the Institutional Review Boards at Johns Hopkins Bloomberg School of Public Health.

Quantitative Methods

PMA resident enumerators (REs) administered the follow-up surveys by phone in either Kiswahili or English, depending on participant preference. To reduce participant burden, 2020 survey content was divided into two separate survey sessions conducted within approximately one week. A total of 1223 participants completed the first session of the 2020 survey, 1217 participants completed the second session of the 2020 survey, and 1177 participants completed the 2021 survey.

All procedures aligned with ethical best practices for sensitive topics (WHO 2016), including specialized training, privacy protections (auditory privacy screener and protocol), and provision of resource referrals (COVID-19 and violence support). Participants' compensation (500 KES, or US$5 per survey) was transferred via M-Pesa. Age, marital status, and Nairobi residence were not eligibility requirements for the follow-up survey.

Qualitative Methods

Synchronous online focus group discussions and interviews (Wirtz et al. 2019) were conducted via the Zoom videoconferencing platform by trained research assistants. Youth participants (age 15-24 years) and stakeholders at community-based organizations (CBOs) were identified via community-partnered recruitment through the assistance of local youth organizations. Participation in the baseline survey was not a requirement for youth to be selected for the qualitative study. FGDs were conducted in August 2020 with youth (8 FGDs; total n=64) and youth-serving stakeholders (4 FGDs; n=32). KIIs were conducted with stakeholders in the fields of adolescent health and SRH. IDIs were conducted with purposefully selected follow-up study cohort members immediately following completion of survey data collection in October 2020 (n=20) and May-June 2021 (n=20). Following a semi-structured guide, topics included family planning, and social, economic, and safety impact of COVID-19 including gender dynamics therein. Discussions were audio-recorded, transcribed verbatim, and translated to English language (if needed) for inductive and deductive thematic analysis.

Measures

Standard demographic assessments included age, main pre-COVID-19 activity (work [formal sector, informal sector, self-employed], student, other), and subjective household socio-economic status (SES). Household SES was determined by asking respondents to situate their household on a ladder, with the lowest rung representing the poorest status and the highest rung representing the wealthiest status.

Health, economic, social, and safety domains aligned with best practices and leading gender empowerment frameworks. Existing measures were utilized when possible, including from Evidence-based Measures of Empowerment for Research on Gender Equality (EMERGE 2017). Likert scales were dichotomized based on underlying distributions to maximize statistical power.

Two binary COVID-19-related risk and perception items examined the level of concern about community spread of COVID-19 and becoming infected. Contraceptive prevalence was measured among respondents with need at that survey round: respondents who were not sexually active at the time of that survey, who wanted to become pregnant within a year at that survey, and female respondents who were pregnant at that survey. Contraceptive dynamics between survey rounds were measured among as respondents with need at both survey rounds in the analysis: respondents who were not sexually active at the time of that survey, who wanted to become pregnant within a year at that survey or at the time of previous survey, and female respondents who were pregnant at that survey or at the time of previous survey.

Depression within the last two weeks was measured via the PHQ2 (Kroenke et al. 2003) and dichotomized on probable depression via symptomology (score >=3).

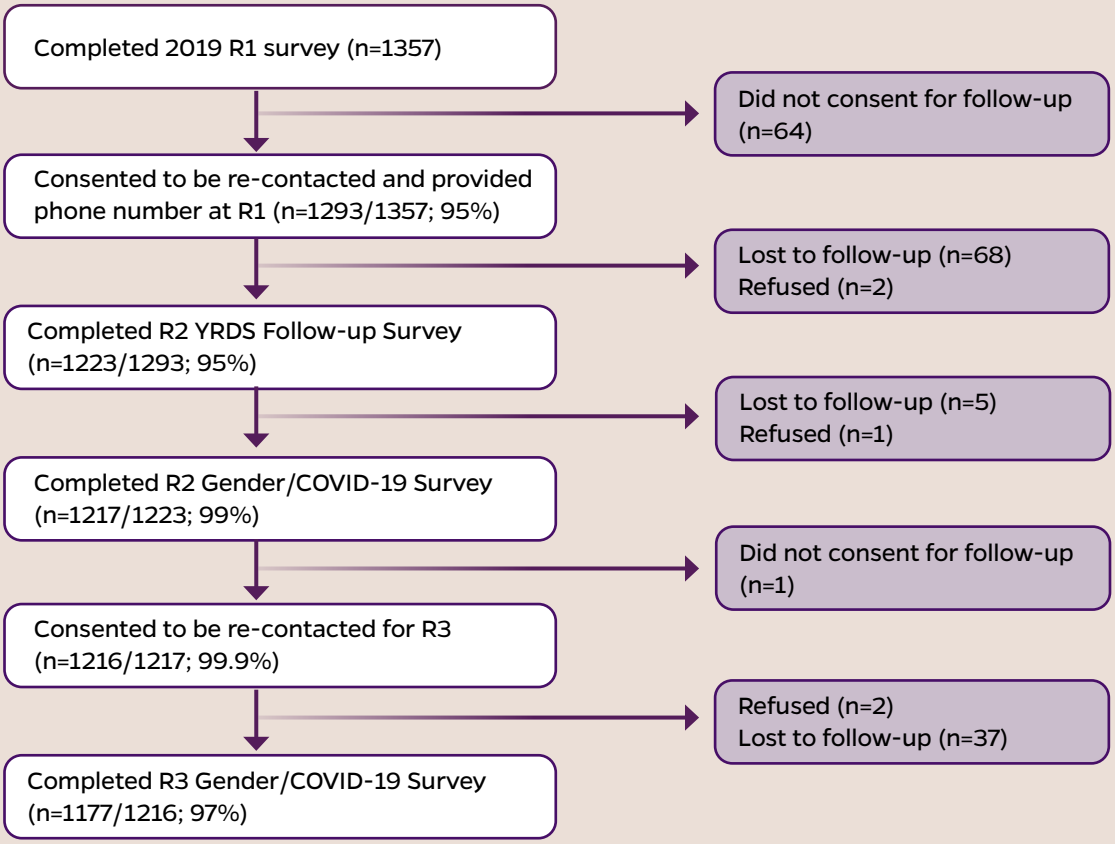
Time use assessment was adapted from the National Statistical Committee Living Standards Measurement Survey (NATSTATCOM 1998); participants were asked to think about a regular day within the past week and indicate how many hours they spent on that specific regular day in the past week on unpaid care for children or adults (unpaid caregiving), on paid work in the formal or informal/gig economy (paid work), on schoolwork or in school (schoolwork; assessed only among those in school pre-pandemic), and on cleaning the house, preparing meals, or washing clothes (unpaid housework). For our analyses, we have combined time spent on caregiving and housework to create an unpaid domestic labor measure.

A 4-point Likert scale assessing current control over decisions to leave the house was dichotomized into full control versus fair/some/little/no control. A 5-point Likert scale assessed current social support (can get the emotional help and support I need from people in my life). Frequency of access to safe, private internet was dichotomized (never/rarely vs. always/sometimes) and current limitations on access further assessed.

To measure safety at home and in public since COVID-19 restrictions, we used a 4-point Likert scale; for outcomes analysis, safety in public was dichotomized (not safe at all in public vs. very safe, somewhat safe, or not very safe). Current fear of police harassment, any interaction with police since COVID-19 restrictions, and police demand for money among those in contact were assessed via single items. For young women, past-year experience of intimate partner violence (IPV), non-partner sexual violence, and timing of IPV experiences relative to COVID-19 restrictions were assessed via best practices for violence research (Center on Gender Equity and Health 2017).

Agreement with gender and violence-related norms was measured using a five-point Likert scale (strongly agree = 5; strongly disagree = 1). Mean scores were calculated for each item. Psychometric analysis of all seven statements showed high internal consistency reliability for six of seven items (Cronbach's alpha of 0.7508 among all respondents).

Figure 2. Recruitment Flow Chart



Findings

Findings from this mixed-methods study demonstrate significant unmet economic, health, social, and safety needs for youth in Nairobi during the COVID-19 pandemic. Concerning gender disparities emerged with young women more economically vulnerable and in greater need of healthcare, while young men faced heightened risk for police violence relative to young women. Gender-specific risks include young women's sustained risk for IPV, increased reliance on transactional partnerships, and gaps in access to menstrual hygiene products. Gender symmetry was identified in mental health burden, and, encouragingly, in the social support that youth felt despite the hardships. Inclusion of a comprehensive set of indicators reflecting both gender and developmental considerations enables understanding of COVID-19's impact on a population that will long grapple with its disruption. While underlying disparities versus COVID-related influences cannot be fully assessed quantitatively, qualitative results speak clearly to the pandemic's impact on economic security, safety, mental health, and access to essential sexual/reproductive health services.

2020 Respondent Characteristics

Table 1 shows demographic characteristics for respondents of the second 2020 phone interview (n=1217). By the 2020 follow-up survey, close to half of respondents were 22-26 years old (46%), most had completed secondary school (57%) or higher (9%), and less than 10% of had married. Gender differences were seen by living situation and main activity before COVID-19 restrictions were implemented.

Table 1. Respondent characteristics at 2020 survey, overall and by gender

	Overall (n=1217)	Gender		
		Young men (n=605)	Young women (n=612)	p-value
	Column %			
Age				0.25
16-18 years	19	19	20	
19-21 years	34	31	36	
22-26 years	46	50	44	
Highest level of schooling completed				0.80
Less than secondary	34	33	35	
Secondary / 'A' level	57	58	56	
College / University	9	9	10	
Married/ Living with someone as if married				0.21
No	91	93	89	
Yes	9	8	11	
Living situation				**<0.001**
Lives alone	23	48	6	
Lives with parent(s) / parental figure(s) with or without other(s)	54	36	67	
Lives with partner with or without other(s), excluding parents	8	4	10	
Lives with others, excluding parents or partner	15	12	17	
Main activity before COVID-19 restrictions (January 2020)				**0.006**
Working	54	61	48	
Student	38	34	41	
Other	9	5	11	
Subjective household wealth tertile				0.49
Lowest (1-3)	39	42	37	
Middle (4)	22	21	22	
Highest (5-10)	39	37	41	

COVID-19
Risk Perception

In the 2020 survey, perceived risk of COVID-19 was high for respondents, with over 80% reporting high concern for community spread and their own risk of infection (community spread: 81% young men, 92% young women; own infection: 84% young men, 96% young women; $p<0.001$). All youth had engaged in at least one preventive behavior at both survey rounds.

Qualitatively, respondents were mixed on the perceived level of concern for COVID-19 transmission and infection among youth. Some cited past epidemics like HIV and Ebola, indicating that COVID-19 would resolve similar to previous health crises.

> "Honestly, I have not seen anyone around be picked with COVID-19, so it is hard for us to believe. Ebola came and it went. Didn't HIV come and we got used to it so what is so big with Corona that it will make you instilled with fear throughout?"
>
> *– 19-year-old female FGD participant (2020)*

Others expressed greater personal concern for COVID-19, particularly for their older family members.

> "Let me say I am 80 percent worried about it because I know it is there. Let me not lie, I am worried about getting it. I am very worried [about my family too] ... I fear for their lives. You know my mum is a bit old and my grandma, my grandmother is not very healthy."
>
> *– 20-year-old female IDI participant (2020)*

Lack of concern translated into continued participation in large gatherings, and low uptake of preventative behaviors, including handwashing and mask wearing. Youth noted several barriers to engaging in preventative behaviors, including a lack of space to social distance, clean water for handwashing, and money for masks.

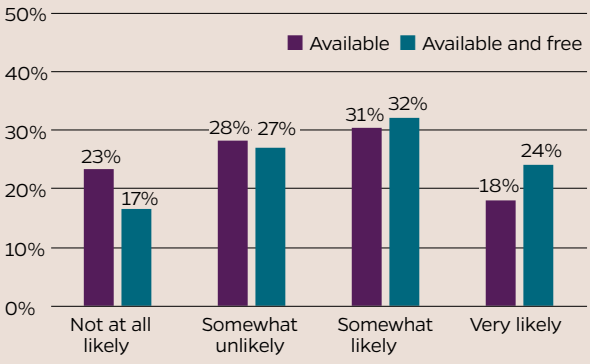
Community Response

New questions on community response to COVID-19 were added to the 2021 survey and found that respondents had mixed feelings on their community's response to the pandemic and the associated mitigation measures. Overall, respondents reported that most people in their community found the governmental guidelines easy to follow (60% very or somewhat true) and that people are taking care to protect themselves and others (65% very or somewhat true). However, the plurality of respondents reported that it was not very true or not true at all that community members are practicing social distancing guidelines (36% and 19%, respectively), with about one-third reporting that this was somewhat or very true. Mask wearing was found to be more common (44% very or somewhat true).

> "I have heard [the] vaccine is being rolled out... Let us say, here in the community [the vaccine is] not easy to get... People in the community have been marginalized a lot... It is very hard for people from down here to go to the centers where the vaccine is being provided... So, we have to spread that information up to households in the grassroots." *– 20-year-old female IDI participant (2021)*

Less than half of respondents reported that youth would be somewhat likely (31%) or very likely (18%) to get the COVID-19 vaccine if it became available in Kenya (Figure 3). These proportions increased slightly when respondents were asked if youth would get the vaccine if the vaccine was free (32% somewhat likely, 24% very likely).

Figure 3. Likelihood youth in Nairobi will get the COVID-19 vaccine based on availability, and availability and cost
Among all 2021 survey respondents (n=1177)



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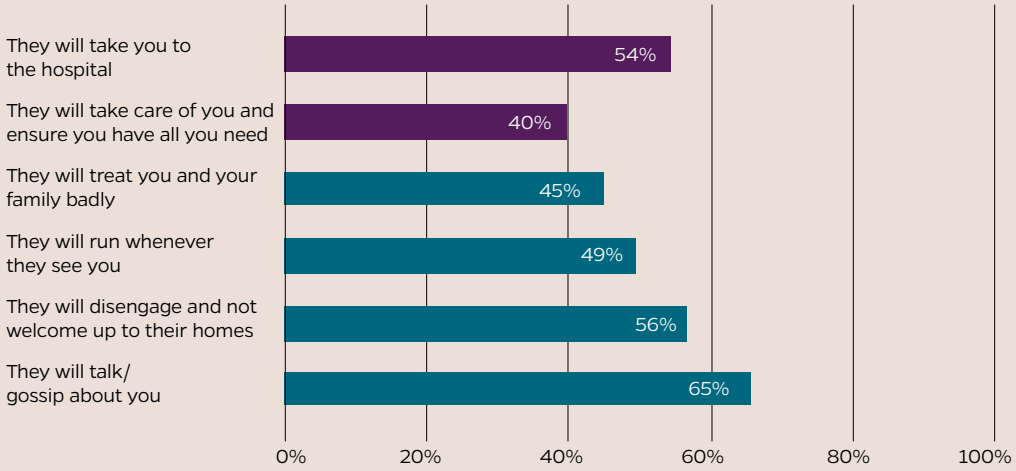
Stigma

Anticipated stigma from community members was high among respondents: over 60% reported that community members would gossip or talk if they knew or suspected that you had COVID-19 (Figure 4). However, over half reported that community members would engage in a positive behavior, specifically, taking them to the hospital. Questions on COVID-related stigma were only asked in the 2021 survey.

Figure 4. Anticipated community responses to suspected or confirmed COVID-19[1] cases
Among all 2021 survey respondents (n=1177)

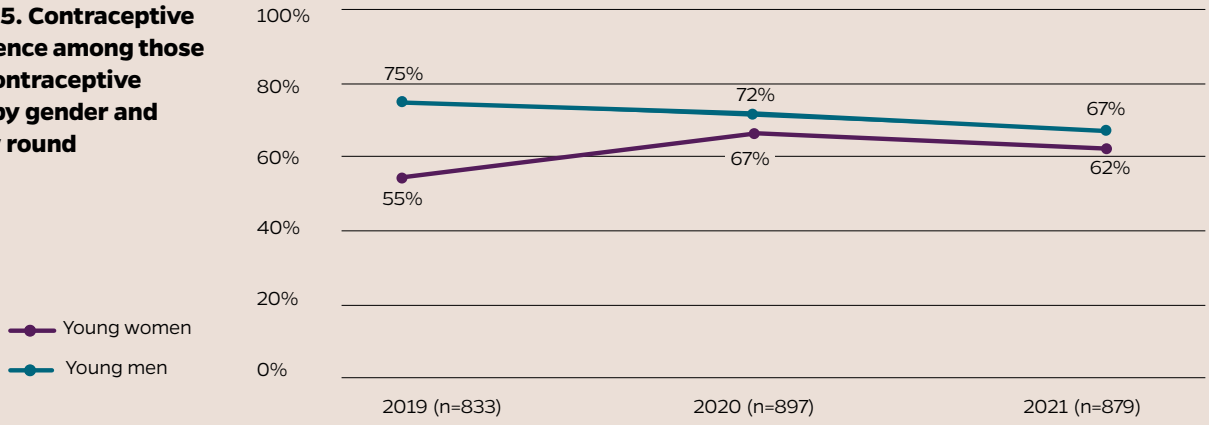


Sexual & Reproductive Health

Contraceptive Dynamics

Contraceptive use was measured at all three survey rounds. The gap between female and male contraceptive use narrowed from 2019 to 2020. The percentage of users had dropped slightly by the 2021 survey for both young women (62%) and young men (67%) (Figure 5). Overall, 69% of respondents with need for contraception at the time of that survey[2] reported using any contraceptive method in 2020 and 64% reported using any contraceptive method in 2021.

Figure 5. Contraceptive prevalence among those with contraceptive need, by gender and survey round



[1] Responses to question: "If you tested positive for COVID-19 today or if people in your community suspected that you have COVID-19, how do you think they will treat you?" Multiple responses could be selected.
[2] Respondents who were not sexually active at the time of that survey, who wanted to become pregnant within a year at that survey, and female respondents who were pregnant at that survey are excluded from this analysis, as their contraception needs would have been low or nonexistent.

In 2020, 27% of respondents were still using the method reported in 2019, 14% had switched methods, and 15% had stopped using a method. In addition, 28% of respondents began using a method and 15% remained non-users. In 2021, 39% of respondents were still using the method reported in 2020, 13% had switched methods, and 14% had stopped using a method. In addition, 14% of respondents began using a method and 21% remained non-users. Details on contraceptive dynamics across rounds by method type among those with a need for contraception across rounds[3] are shown in Figure 6 (young women) and Figure 7 (young men).

> Mostly, now... let's say [I] just [use] P2 [emergency contraception]. Because I know... my friends also tell me that P2 is safe... That it does not have any effects [like] those other injections [long-acting contraceptives].
>
> *– 23-year-old female IDI participant (2021)*

Figure 6. Contraceptive use dynamics among women with need across survey rounds

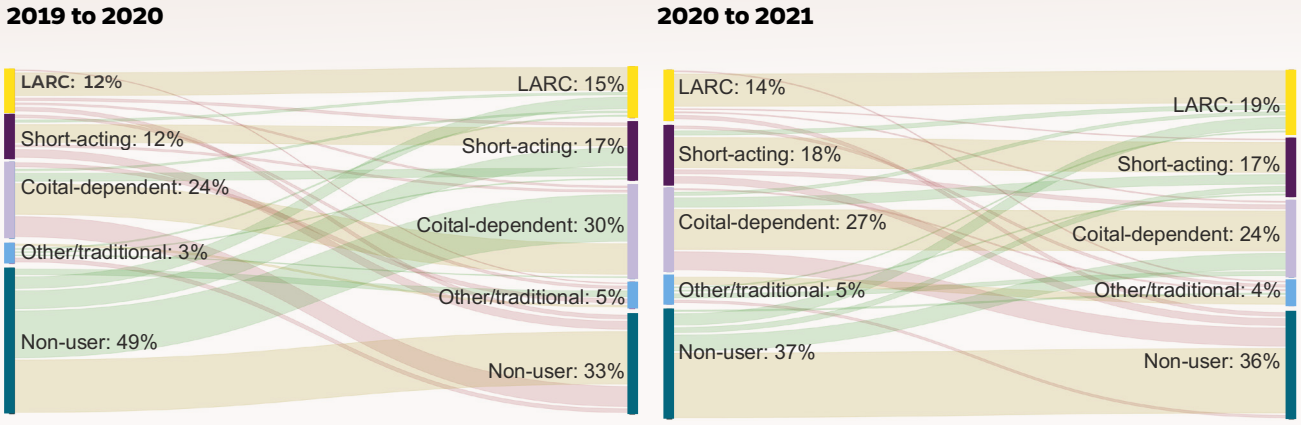
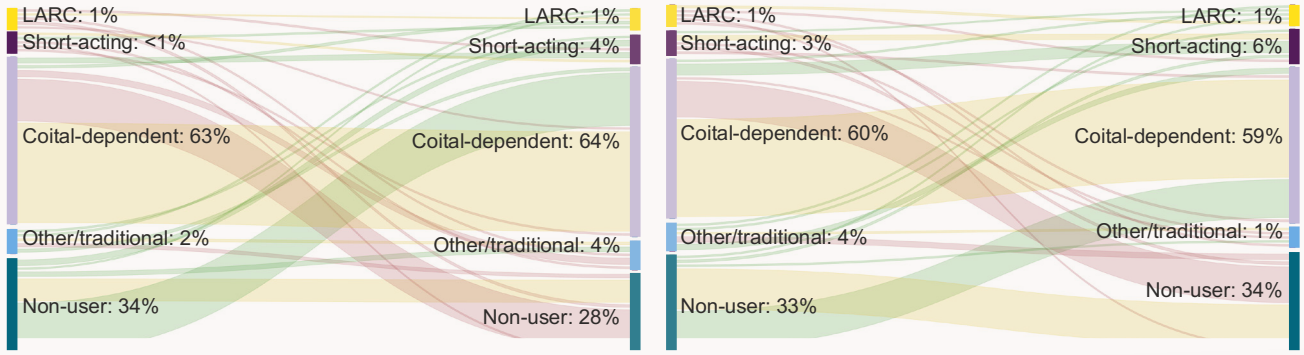


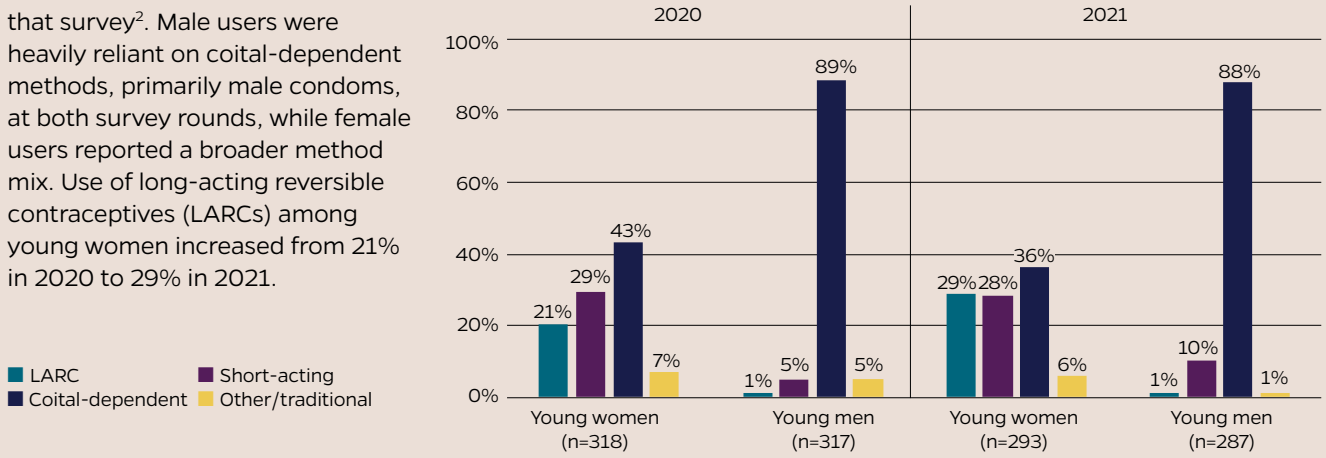
Figure 7. Contraceptive use dynamics among men with need across survey rounds



[3] Respondents who were not sexually active at the time of that survey, who wanted to become pregnant within a year at that survey or at the time of previous survey, and female respondents who were pregnant at that survey or at the time of previous survey are excluded from this longitudinal analysis.

Figure 8 shows the method mix by gender and survey round among those with need at the time of that survey[2]. Male users were heavily reliant on coital-dependent methods, primarily male condoms, at both survey rounds, while female users reported a broader method mix. Use of long-acting reversible contraceptives (LARCs) among young women increased from 21% in 2020 to 29% in 2021.

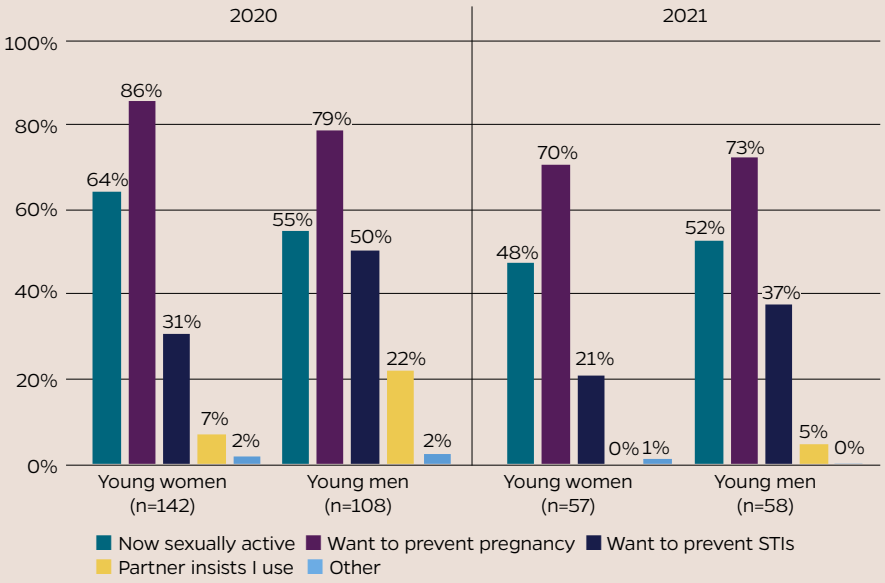
Figure 8. Contraceptive method mix among those with contraceptive need, by gender and survey round



At both survey rounds, wanting to prevent pregnancy was the primary reason for method uptake for both young women and young men, followed by becoming sexually active (Figure 9).

Male switchers in 2020 were most likely to report partner-related reasons; however, in 2021, "inconvenient to use" was the most common reason for switching methods among young men. For female switchers at both rounds, medical reasons, like fear of side effects and health concerns, were most reported for switching their method at follow-up. Ease of use was also highlighted as a reason in qualitative interviews. Qualitative data also highlighted method convenience as reason for switching from a short-acting to long-acting method and the influence of a friend's negative experience with a method influencing the participant's own method uptake.

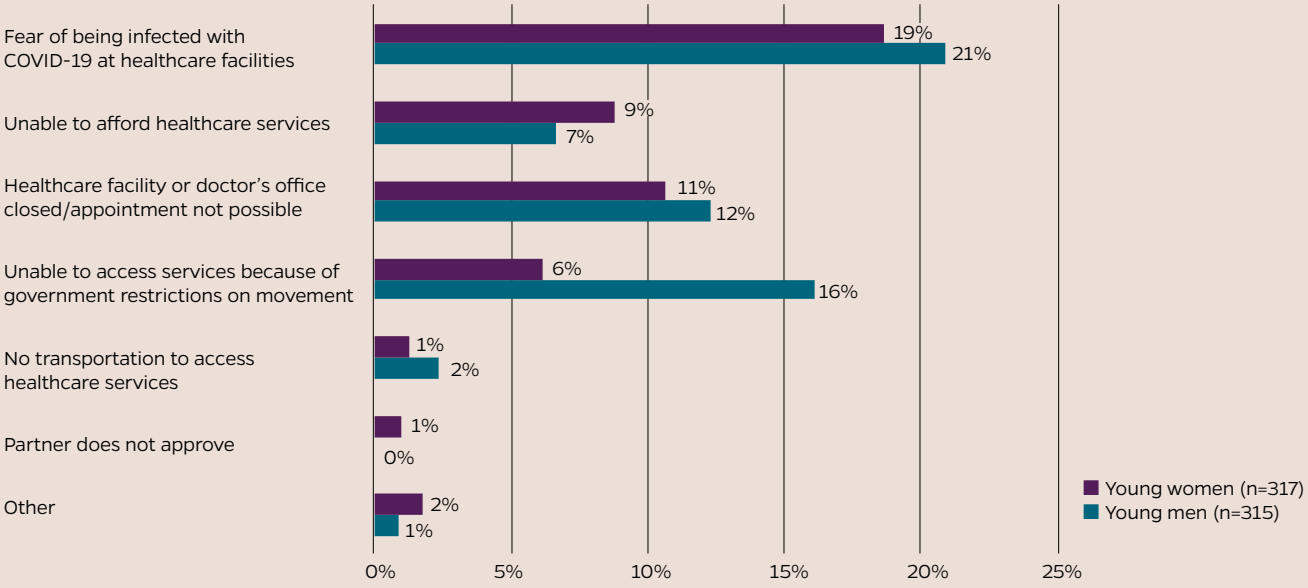
Figure 9. Reasons for contraceptive uptake among new users, by gender and survey round



> Maybe your friend was using a certain method... And it affected her negatively so even you whatever you had planned even you, you can also think that it can affect you negatively so you stop or mute, you can stop, and you can switch using those methods.
>
> *– 22-year-old female FGD participant (2020)*
>
> I was using pills. I saw that [to use] those pills, it is a must you go to the hospital [and] you pick them [up]. But this [IUD], when it is inserted, that is all. I will just go for checkup when it is over those years.
>
> *– 18-year-old female IDI participant (2021)*

Fear of infection was identified as a key barrier to accessing SRH services specifically in 2020. Access to condoms, both due to stockouts and money constraints, was also a key issue discussed within focus group discussions.

Figure 10. Contraceptive disruptions since COVID-19 restrictions among users in 2020, by gender



When asked about disruptions to accessing their primary contraceptive method in 2020, 41% of male users and 35% of female users reported experiencing any difficulty accessing contraception since the start of COVID-19 restrictions (Figure 10)[4].

> Most right now that were using [contraception] fear to go to hospital, why? You can go to the hospital you be tested and be told you have Corona; you be told to go to quarantine. No one wants to go to quarantine.
>
> *– 23-year-old female FGD participant (2020)*

> So, you find like that... 50 shillings to go to buy [a] condom [but] you find that also to get job is hard at the moment. So, that 50 [shillings] you will think of food [rather] than [a] condom.
>
> *– 22-year-old male FGD participant (2020)*

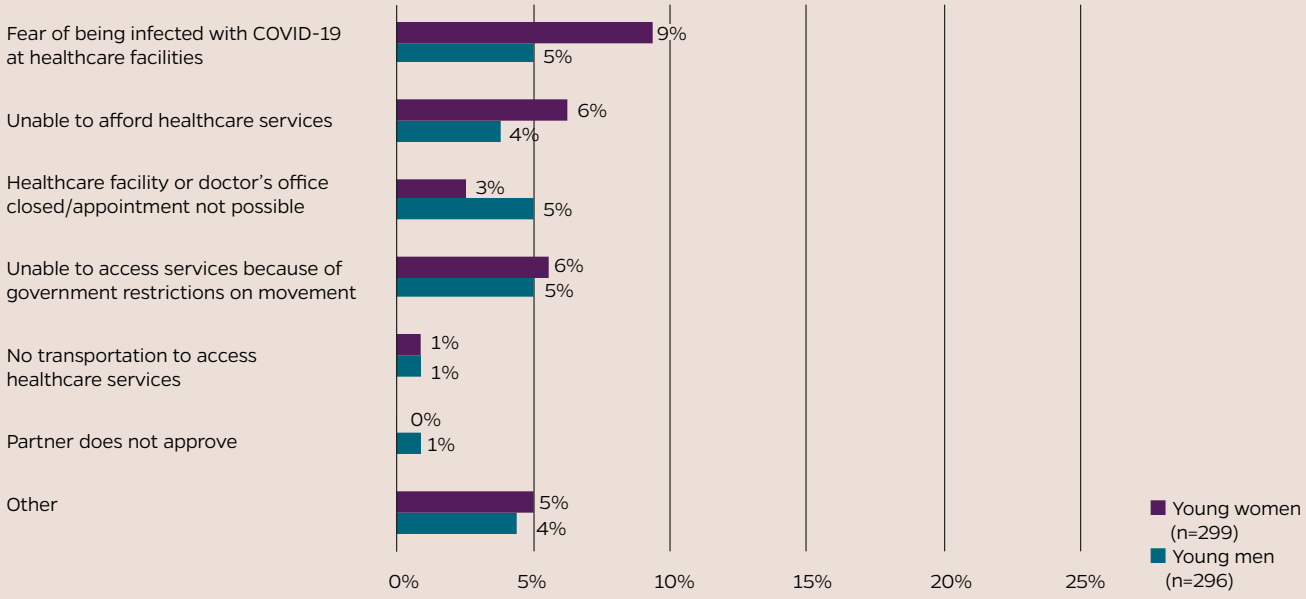
> "[I] have been having some discussions with young women and young girls, who had previously received a contraceptive service and especially LARC services. During that period of lockdown, they were experiencing side effects, and because of the restrictions in movement they were unable to access further counseling on side effects which they were experiencing."
>
> *– 30–35-year-old male officer at contraceptive service provider – FGD with youth-serving stakeholders (2020)*

Some youth discussed closure of services and contraception distribution sites, which particularly affected condom users.

> With young men, before COVID started, in the hospital there was this place for keeping condoms. Right now, they don't keep it. So that they can try to avoid that overcrowding or those people who keep coming to hospital every time.
>
> *– 22-year-old female FGD participant (2020)*

By the 2021 survey, users reporting barriers to contraceptive access dropped overall: 18% of male users and 21% of female users experienced any difficulty accessing contraception in the 6 months preceding the 2021 survey (Figure 11).[4] Fear of contracting COVID-19, the most common barrier reported in the 2020 survey (19% of female users and 21% of male users), had decreased in the 2021 survey (9% of female users and 5% of male users).

Figure 11. Contraceptive disruptions in past 6 months among users in 2021, by gender



Pregnancy

Participants were asked about pregnancy status, if female, or their current partner's pregnancy status, if male, at each survey round (Table 2). For both young women and young men, reported pregnancy was highest in 2020: 5% of young women were pregnant and 6% of young men reported that their partner was pregnant at the time of the survey.

Table 2. Pregnant or partner pregnant at the time of survey, by survey round
Among respondents who completed all three survey rounds (n=1177)

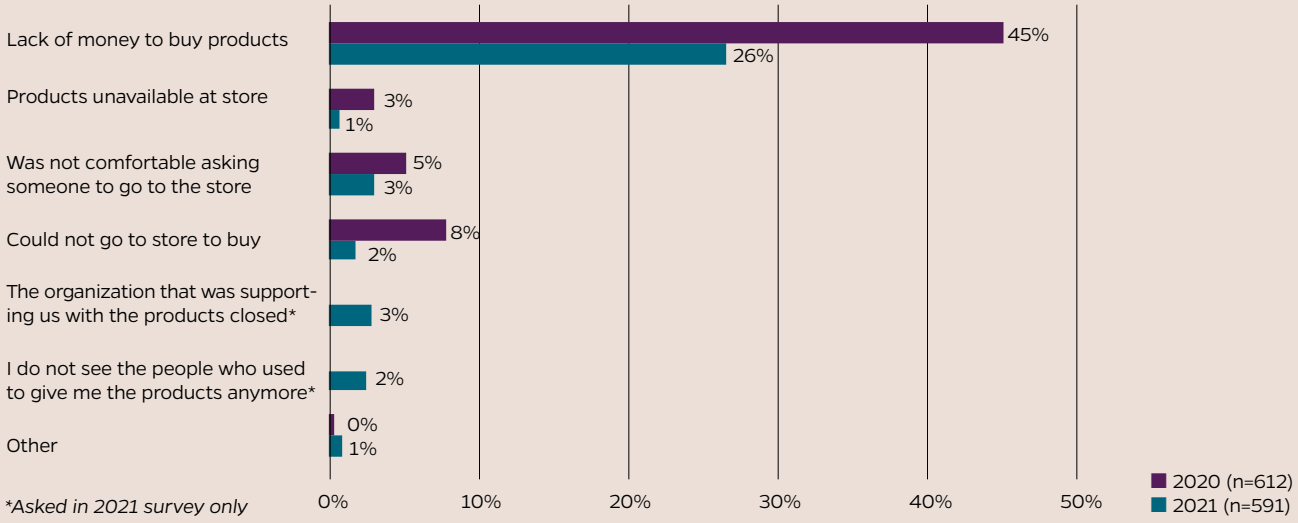
	2019	2020	2021
Pregnant (if female) at time of survey	1%	5%	2%
Partner pregnant (if male) at time of survey	4%	6%	4%

[4] Contraceptive users who reported rhythm method/safe days, LAM/exclusive breastfeeding, withdrawal, "do not know", or "no response" as their main method not included

Menstrual Hygiene Management

In 2020, over half of young women reported disruptions to accessing menstrual hygiene management (MHM) products since the start of COVID-19 restrictions (52%). Fewer young women reported disruptions to accessing menstrual hygiene products in 2021: 30% overall. At both timepoints, barriers concentrated around lack of money to buy products (45% in 2020 versus 26% in 2021; Figure 12).

Figure 12. Barriers to accessing menstrual hygiene products among young women, by survey round



Overall, 38% of female respondents experienced no menstrual product access challenges and 32% resolved challenges over the course of the pandemic, however, 10% of AGYW acquired challenges between 2020 and 2021 and 20% sustained challenges across time points.

Access to Healthcare

As compared with young men, significantly greater proportions of young women attempted to access health services during COVID-19 and experienced disruptions to access (20% young men; 33% young women; $p<0.001$). Approximately 40% of young men and 35% of young women using contraception faced difficulty procuring their method(s). Over half of young women (52%) reported a challenge procuring menstrual hygiene products, overwhelmingly due to a lack of money (45%).

Qualitative data corroborated that COVID-19 barriers to health centered on fear of accessing services, financial barriers, and facility closures. All groups highlighted COVID-19-related fear as the predominant barrier to accessing hospital and contraceptive services.

> So, going to hospitals where actually people leave the Coronavirus, they are taken and admitted, and the doctors are trying to help them is a major risk. We are exposing ourselves. We are afraid to go because we might get it.
>
> *– 15-year-old male FGD participant (2020)*

> You cannot go to the hospital. There could be rumors that you are disappearing at night and then you get sick, with that rumor you start to sneeze, cough and most of them say it is COVID. So, you cannot even go to the hospital. So, this COVID has affected so much that.
>
> *– 17-year-old female FGD participant (2020)*

Mental Health & Social Support

In both survey rounds, respondents were asked about depressive symptoms experienced in the previous two weeks. From 2020 to 2021, reported depressive symptoms decreased for both young men and young women: 24% to 20% of young women and 22% to 15% of young men. However, qualitative interviews showed continued mental health stressors for young people during the pandemic.

> People nowadays have known there is no money and also one can give hard work and then [employers] give you little money... So, the stress has remained the same [during COVID], [whether] there are restrictions or there isn't.
>
> *– 17-year-old male IDI participant (2021)*

Youth described mental health consequences of the COVID-19 pandemic. Feelings of depression and stress among youth were attributed to job loss and financial constraints, compounded by idleness in the home.

> I think due to lack of job opportunities and the way people have lost their jobs, man, it has led to depression. You are there and there are people who want to eat, I mean they depend on you ... I think most of the people are getting depressed... I mean, till you are losing it, you are really losing it, you don't know what you will do.
>
> *– 19-year-old female FGD participant (2020)*

Both stakeholders and youth pointed to isolation as a chief concern, and highlighted needs for youth-oriented mental health services and counseling.

> I've missed some of my friends... then also keeping away people that, that you love, you know. It's not; it's not easy. Aah for the last two months, I was not that able much because I was mostly using the social media, yeah. And you know the expenses of social media so that could not allow me to always contact them regularly.
>
> *– 24-year-old male IDI participant (2020)*

> At the moment the greatest need according to me for youth now is psychological support. ... the way conditions are now considering COVID-19, the way status of the family is, you see how status has been, the way poverty has started to reign in the family.... So, [youth] see as if there is no other solutions on the problems they have now. So right now, they need counseling [on] how they will handle these stress they have at the moment.
>
> *– 19-year-old male FGD participant (2020)*

Despite reported feelings of depression and isolation, 89% of respondents strongly agreed or mostly agreed that they had someone they could "share [their] joys and sorrows with" in the 2020 survey. In addition, 87% strongly agreed or mostly agreed that they had someone "to count on when things go wrong." Mothers and friends were the most reported sources of social support in both survey rounds.

Economic & Educational Impact

Approximately half of youth reported being unable to meet their basic needs since the onset of COVID-19 restrictions (45% young men; 53% young women) and young women were more likely to report economic hardship compared to young men (88% vs. 37%, respectively).

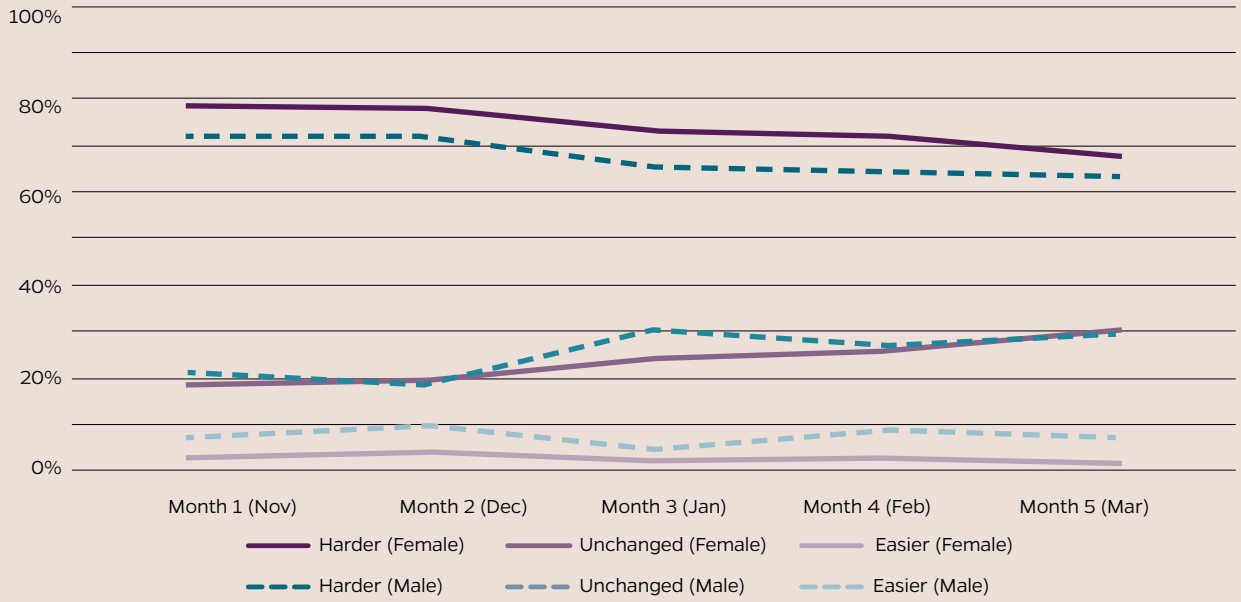
While survey data lack a pre-pandemic baseline on unmet economic needs, qualitatively, young men and women described profound economic impact via job loss and loss of income for themselves and their families in the wake of the COVID-19 restrictions, prompting financial uncertainty, loan-taking, and food insecurity.

> "[Lack of] house rent has seen my mum and my grandmother almost being thrown out of the house. It is my grandmother who begs [the landlord]. She tries to talk to them in a nice voice and tell them it is just because of the Corona times... He cannot afford to throw us out because he is a human by the end of the day. Another financial challenge is about the food, but I still thank God at least we can eat once in a day... there are some people who usually go without food.
>
> *– 20-year-old female IDI participant (2020)*

> "You find that a member of the family maybe used to work in a certain industry... then due to this COVID-19 they lose their jobs... So, the breadwinner becomes one person [instead of having two] so challenges are many in the house... Shopping for food for the house, everything has just changed... You may find even that in some families both the breadwinners have lost their jobs.
>
> *– 15-year-old male FGD participant (2020)*

Between survey rounds, respondents were invited to submit a monthly mini survey via text message, which included one question on ability to meet basic needs in the prior month. Both young women and young men were less likely over time to report that it had become "harder" to meet basic needs in the month prior (Figure 13).

Figure 13. Changes in ability to meet basic needs in the prior month, by gender
Among mini-survey respondents (n=1032, monthly average)



Participants were also surveyed about how they allocate their time during a typical day in both survey rounds. Results from those survey items are presented in Table 3. Young men were more likely to spend time doing paid work, while young women spent more time doing unpaid domestic work at both time points (<p<0.05).

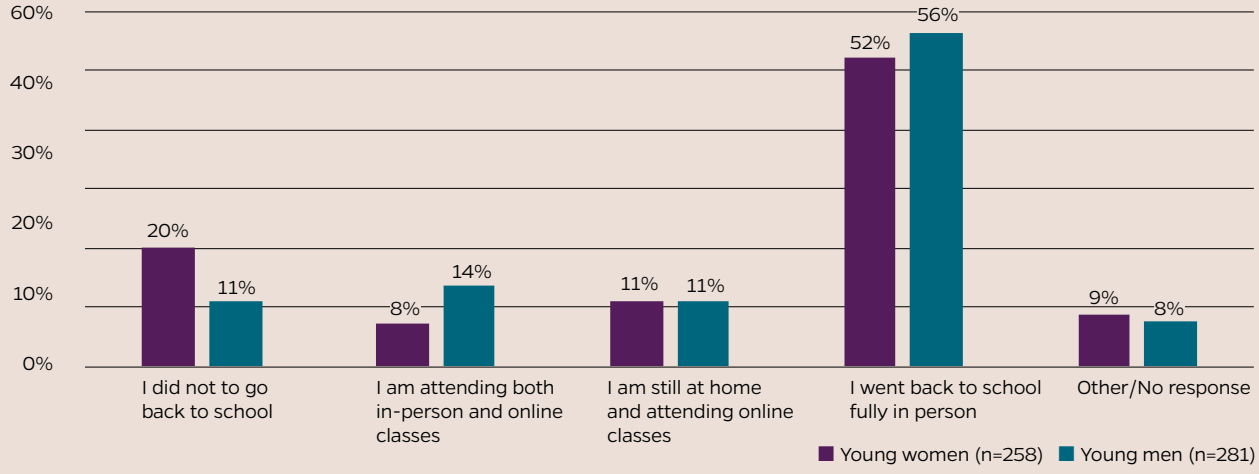
Table 3. Time use and change in time use, by gender and survey round

	2020 Hours in a typical day			2021 Hours in a typical day			Difference 2021–2020	
	Young Women	Young Men	Men–Women Estimate (95% CI)	Young Women	Young Men	Men–Women Estimate (95% CI)	Young Women (95% CI)	Young Men (95% CI)
Paid work	1.8	3.7	1.9* (1.4, 2.4)	2.2	3.8	1.6* (1.1, 2.2)	0.3 (0.0, 0.6)	0.1 (-0.3, 0.4)
Schoolwork+	1.8	2.1	0.3 (-0.3, 0.9)	3.2	3.3	0.1 (-0.7, 0.8)	1.4* (0.8, 2.0)	1.2* (0.5, 1.9)
Unpaid domestic work	4.6	2.2	-2.4* (-2.9, -2.0)	3.9	2.0	-1.9* (-1.1, -1.5)	-0.7* (-1.1, -0.4)	-0.2 (-0.4, 0.1)

**p-value<0.05; means testing adjusting for weighting and clustering*
+Sample limited to those who report being a student is their main activity at both time points

Of the 539 students in 2020 and 2021 (281 young men and 258 young women), 56% of young men and 52% of young women reported that they went back to school fully in-person at the time of 2021 data collection, 11% of both young men and young women were continuing online school, and 14% of young men and 8% of young women were attending both in-person and online (Figure 14). A higher proportion of young women did not return to school in 2021 compared to young men (20% to 11%), most commonly because parents did not have money to pay school fees (34% among young men and 46% among young women) or because the respondent graduated (47% among young men and 36% among young women).

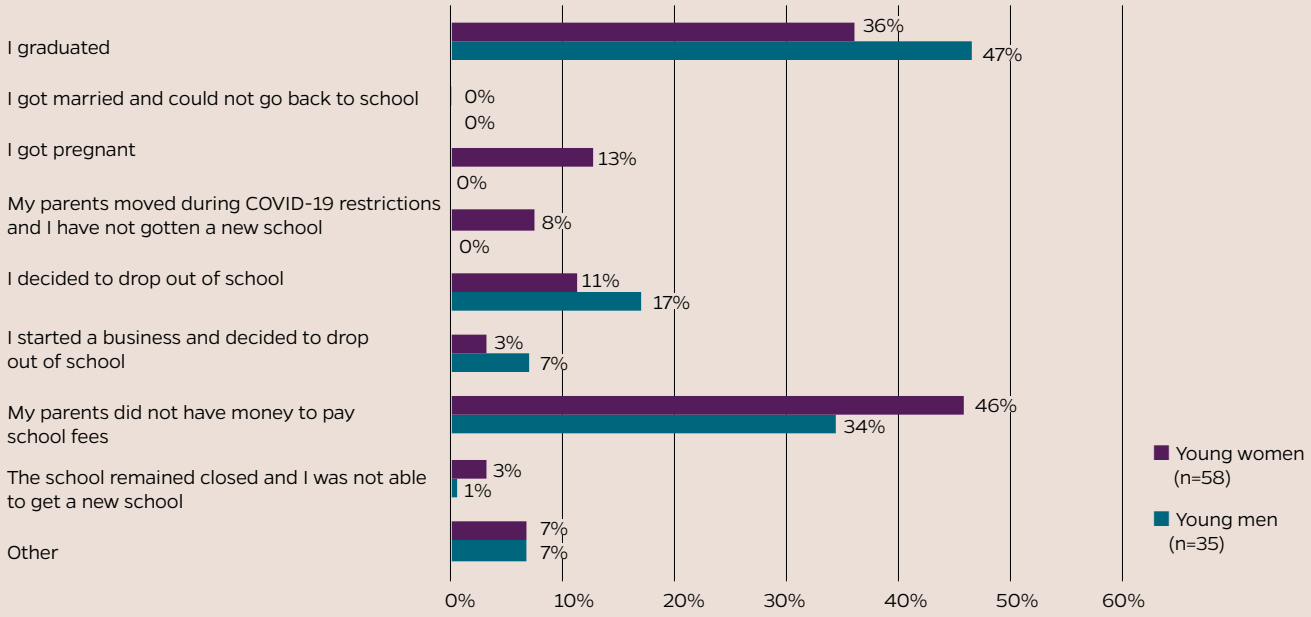
Figure 14. Learning situation in 2021 among current or former students, by gender



> Because now the... jobs have reduced. There is no money. Right now... let us say per day a hairdresser can plait one person and she has a family, and you want to go to school... Now you see, even when you go to school, you are chased away due to school fees.
>
> *– 18-year-old female IDI participant (2021)*

A higher proportion of young women did not return to school in 2021 compared to young men (20% to 11%) (p=0.04) and young women were more likely to not return to school because of lack of school fees (46%) compared to young men (34%) (Figure 15).

Figure 15. Reasons for not returning to school in 2021 among former students, by gender



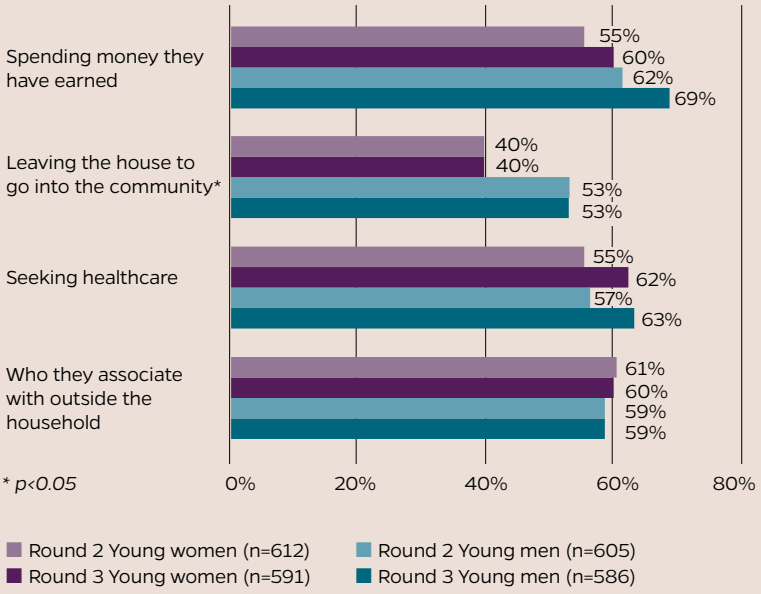
Mobility, Privacy & Access to Technology

During COVID-19, control to leave the house differed significantly by gender (p<0.05), with women indicating less control over their decision (Figure 16). Almost half of both young men and young women reported decreased time spent with their partner because of COVID-19 restrictions, though just over a third reported increased time with partners. Over three-quarters indicated high social support and strongly agreed or agreed that they were able to get needed emotional help and support. Inability to access safe and private internet disproportionately impacted young women (26% young men; 34% young women; p<0.001).

> Sometimes you want to dress… maybe it is a single room… they [male family members] come and go… you to dress up now you are stuck. How you dress, and those men are there? You say there is no privacy for you as a girl.
>
> *– 23-year-old female FGD participant (2020)*

> At the moment, there is no one going to work outside of the house… So, everyone is in the house, both parents. COVID 19 has led to loss of jobs… So, it forces parents to move to smaller houses. Of which it will affect the privacy of everyone… You find that there your relatives have been chased away because of rent… They come and stay with you in the house… So, you see if you had your own room, you have to share.
>
> *– 19-year-old male FGD participant (2020)*

Figure 16. Respondents reporting full control over activities, by gender and survey round



Across combined and gender-stratified multivariable models, living independent of parents was associated with increased decisional control to leave the house ($p<0.001$). Students were less likely to be able to access private internet than non-students in combined (aOR=1.31; $p<0.05$) and woman-specific (aOR=1.59; $p<0.01$) models. In male-only models, young men with lowest abilities to meet basic needs indicated increased inability to access private internet (aOR=2.36; $p<0.01$).

Qualitative data highlighted unique privacy constraints given COVID-19 mitigation measures that prompted more time at home. The economic disruption of COVID-19 led families to move into smaller homes with extended family members, limiting privacy. Young women described unique privacy constraints including basic hygiene, getting dressed, and studying in the home.

Young women described constrained autonomy and mobility, including needing parental permission or supervision from older, male relatives to leave the house. In comparison, mobility barriers for young men focused on fear of contracting COVID-19 and of police harassment.

> Right now... you must tell your parents where you went to, even when you just want to leave, they tell you if you have got brothers... They will go with you wherever you go. So, even when you want to go to the shop you are told to go with your elder brother.
>
> *– 17-year-old female FGD participant (2020)*

> [Before COVID-19] I could go to different places. I could go any time wherever I want because I always, I was always on my own principles... but... I fear that, that maybe I will go to somewhere then maybe I can contract the COVID.
>
> *– 24-year-old male IDI participant (2020)*

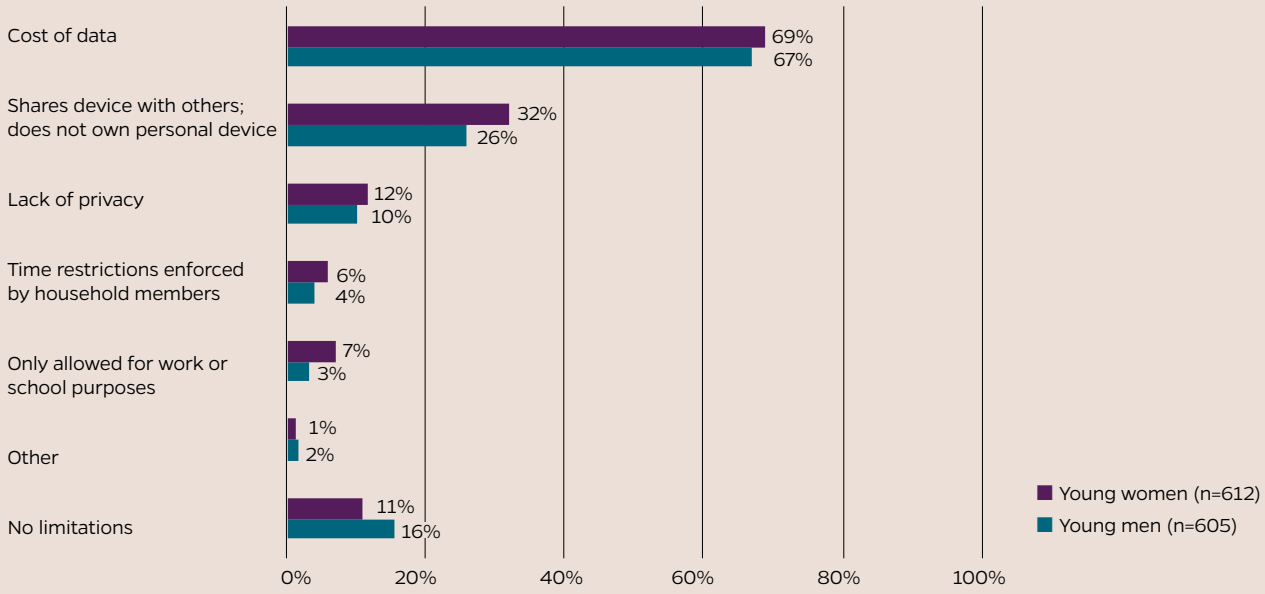
Stakeholders explained mobile technology as a lifeline for youth to remain connected with social networks; yet the scarcity of privacy undercut this tool, prompting some young women to seek privacy outside the home, even in restrooms.

> The young people most of them they like [to be]... social with their friends, with their peers, so they are now... being restricted to stay at home or even if they go, there is no social gathering. So that safe space for them, there is no safe space for the young people, be it at home [or] be it outside... Now the technology is moving whereby... you can... talk through WhatsApp... or Facebook chat. But in the household level... all people are within [the home,] you are not be able even to talk privately with that person.
>
> *– 35-40-year-old male youth advocate – FGD with youth-serving stakeholders (2020)*

> [To have private communication you go] In paid toilets... Or you go down there to the river... In a place you are not known, you talk about your stories and then come back.
>
> *– 24-year-old female IDI participant (2020)*

Inability to access safe and private internet disproportionately impacted young women in the 2020 survey, wherein 26% of young men and 34% of young women reported that they rarely or never had a safe and private way to access the internet (p<0.001). Gender differences in internet access improved slightly by the 2021 survey (25% young men and 30% young women; p=0.22). In 2020, respondents reported their barriers to internet access, which was most often cost of data (Figure 17).

Figure 17. Limitations on internet access in 2020 among all respondents, by gender



Safety & Violence

Safety at Home & in Public

In 2020, both young men and young women felt moderately safe at home (>70%), although young women felt more unsafe in public spaces compare to young men (16% young men; 21% young women). Feelings of physical safety in public increased from 2020 to 2021 among both young men and young women: only 34% of men and 26% of women felt very or somewhat safe in 2020, increasing to 53% of men and 51% of women in 2021. Safety in the home was not asked in the 2021 survey.

Interactions with Police

Data on police interactions were only captured in the 2020 survey. Interactions with police since COVID-19 restrictions were more prevalent among young men compared to young women (60% vs. 38%, respectively; p<0.001); 55% of young men's contacts included police extortion (money or bribes), which emerged in the qualitative data, as well.

> "I think young people are being violated based on this Corona virus because, let me say for example, you are supposed to be at home by 9, and by mistake you find yourself outside and if you might meet police and they might brutally beat you, or beat you physically, which is abusive."
>
> *– 18-year-old male FGD participant (2020)*

Sexual Harassment

Female respondents were asked about their experiences with sexual harassment in the 2020 survey only. Slightly less than one-fifth of young women (18%) reported experiencing sexual harassment, behaviorally defined as "unwanted sexual attention or harassment such as verbal comments, staring or leering, or unwanted physical contact like groping or grabbing", in the past 12 months. Of those who reported sexual harassment, 15% only experienced this before COVID-19 restrictions, 19% since COVID-19 restrictions, and 67% at both time points. Finally, among those who experienced both prior to and during COVID-19 restrictions, 35% said sexual harassment has increased since COVID-19 restrictions, 45% saw no change, and 21% said it decreased.

IPV & Non-Partner Sexual Violence

In both the 2020 and 2021 surveys, a similar proportion of partnered young women reported an experience of physical intimate partner violence (IPV): 14% in 2020 and 14% in 2021. Overall IPV prevalence was 17% past-year in 2020 and 18% past-six months in 2021. Non-partner sexual violence prevalence was similar in 2020 (3%; past-year) and 2021 (3%; past six months). Table 4 provides additional estimates on IPV and non-partner sexual violence among young women across survey rounds.

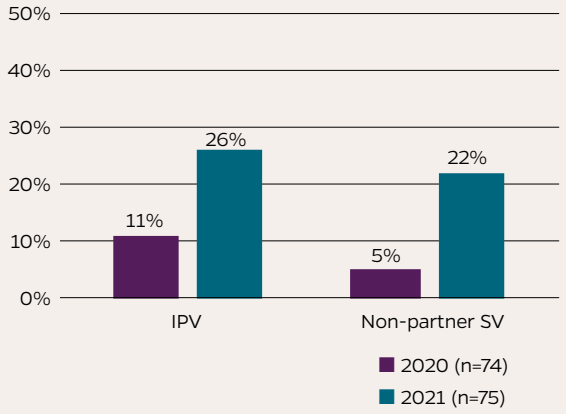
Table 4. Prevalence of past-year IPV and non-partner sexual violence, by survey round and changes since COVID-19 restrictions among young women

	IPV	Non-partner sexual violence
	% (n*)	
2019	n=550	
Prevalence with current/former partner±	18 (96)	--
2020	n=449	n=612
Prevalence (past 12 months)	17 (78)	3 (18)
Timing relative to COVID-19 restrictions[1]		--
Before-COVID-19 restrictions only	30 (20)	
Since COVID-19 restrictions only	43 (29)	
Both time periods	27 (18)	
Change in intensity since COVID-19 restrictions if experienced during both time periods[2]		--
Decreased	19 (4)	
No change	33 (6)	
Increased	49 (9)	
2021	n=404	n=591
Prevalence (past 6 months)	18 (71)	3 (18)

** Weighted*
± Item wording specifies ever violence experience with current or former (if no current) partner
-- Item not measured at specified time point
1. Among those with past 12-month IPV at mid-pandemic (n=67 unweighted; n=78 weighted)
2. Among AGYW who reported IPV both before and since COVID-19 pandemic (n=19 unweighted; n=18 weighted)

Among young women who experienced, 11% sought help in 2020 and 22% sought help in 2021, respectively (Figure 18). Similar increases in help-seeking across timepoints were seen among young women who reported non-partner sexual violence (5% in 2020; 15% in 2021).

Figure 18. Help-seeking for IPV and sexual violence among young women, by survey round
Among young women reporting experience of IPV or sexual violence

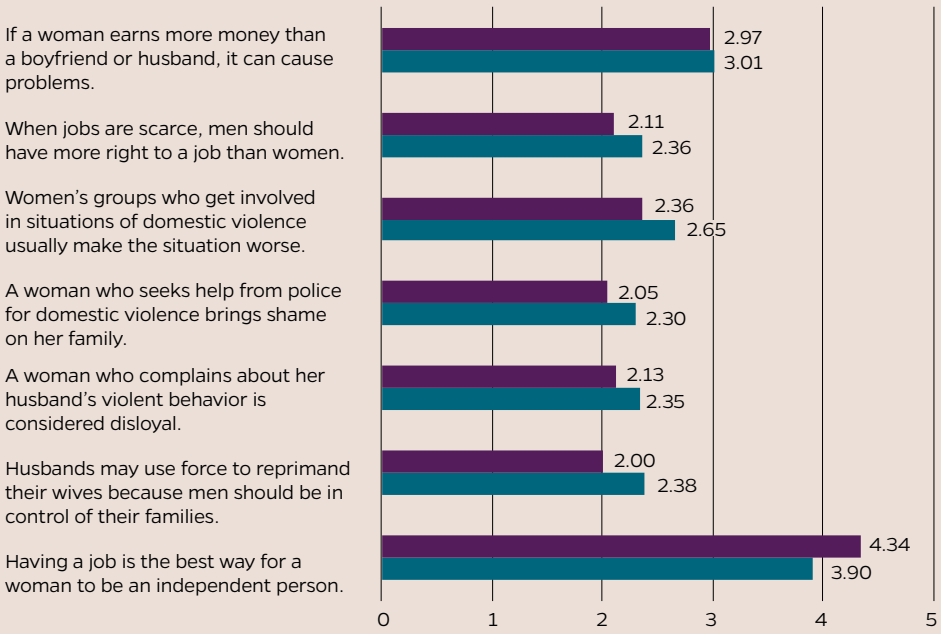


> Now there are curfew hours so maybe you went out... and time went by without you noticing... And you are with this guy... And now he has the chance to do with you anything he likes because he knows you can't go anywhere, it is past curfew, you can't leave the house. So, he might do anything to you.
>
> *– 17-year-old female FGD participant (2020)*

Social Norms

In the 2021 survey, respondents were asked a series of questions about social norms surrounding gender, violence, and help-seeking (Figure 19). Response options ranged from strongly disagree (1) to strongly agree (5).

Figure 19. Gender and violence-related norms (mean score) among all 2021 respondents, by gender



The overall α coefficient for the first six survey items 0.7508 overall, 0.7813 among male respondents, and 0.7008 among female respondents. The last survey item in Figure 19, "Having a job is the best way for a woman to be an independent person" was dropped from the scale due to lower item-rest correlation.

Discussion

Current evidence of gender disparities and gender-specific risk in Nairobi likely reflect a combination of pandemic-specific influences together with underlying disparities. Results suggest the potential for far-reaching social, economic, and health consequences for generations to come. As youth transition back to school, monitoring is needed to ensure gender equity and offset potential gaps, including those related to supplies, school fees, and technology access. Global and national COVID-19 recovery represents an opportunity to rectify gender and socio-economic disparities while mitigating the pandemic's disruption. Gender-inclusive and youth-inclusive decision-making are essential yet concerning gender gaps persist in COVID-19 decision-making entities, including in Kenya. Gender-responsive guidance must shape response and recovery efforts, including meeting gender- and age-differentiated needs, and ensuring gender-stratified monitoring and impact evaluation (van Daalen et al. 2020). The COVID-19 pandemic represents a global wake-up call on gender and socio-economic disparities; equity must drive its resolution. To effectively respond and potentially limit the long-term economic, health, education, and safety impacts for young men and women, governments must have the courage to make bold and comprehensive investments in their populations, with a targeted and gender responsive approach to meet the needs of those most impacted by the pandemic.

Strategic Youth Engagement

This study was strengthened by extensive engagement with young people in Nairobi County at all phases of the process, to inform the study design, ensure the relevance of domains assessed, contextualize quantitative results, interpret findings, guide recommendations, and deepen learning through their experiences. A few examples of PMA & ICRHK's strategic youth engagement include:

- Normative research, including focus group discussions and cognitive interviews, before 2019 baseline data collection to inform survey questions and RDS implementation
- Focus group discussions with young people aged 15-24 in 2020; in-depth interviews with quantitative survey participants in 2020 and 2021
- Involvement of Youth Advisory Council (YAC) members in dissemination events, as planners and speakers
- Youth storytelling capacity building and experience sharing in collaboration with Stoop Stories, a Baltimore-based storytelling event group, for February 2021 global webinar
- Onward dissemination of research findings through youth groups and youth participants (see Appendix 3: Social Media Snapshots)

Strategic Dissemination

Strategic results dissemination enabled reach to a breadth of policy, practitioner, and academic audiences. Emergent results were disseminated in real time with peer researchers through participation in virtual events and roundtables including the Learning Initiative on Norms, Exploitation and Abuse (LINEA) Project of London School of Hygiene and Tropical Medicine, the EMERGE project of University of California San Diego's Center for Gender Equity and Health, and with the KU WEE Hub's COVID-19 and GBV working groups.

Following a smaller data validation workshop in November 2020, a results dissemination was held in Nairobi, Kenya later that month, where the first wave of topical policy briefs was released. This event received extensive media coverage, including livestream coverage from NTV Kenya.

A virtual event was held in February 2021, enabling reach to a global audience of policy stakeholders, practitioners, and scholars. This event featured a review of global data from the Global Gender/ COVID-19 Working group, youth voices convened by Stoop Stories, results presentation, and panel discussion featuring Julie Mwabe, Gender Advisor to the President; Dr. Anne Kihara, OBGYN; Dr. Grace Wamue-Ngare of KU WEE Hub; Anne Ngunjiri-Gakuya, Gender Expert and Sr. Technical Advisor LVCT Health; and Virginia Nduta, Executive Director, Women's Empowerment Link. For the event agenda, please see Appendix 1: February 2021 Gender in the Pandemic Webinar Agenda.

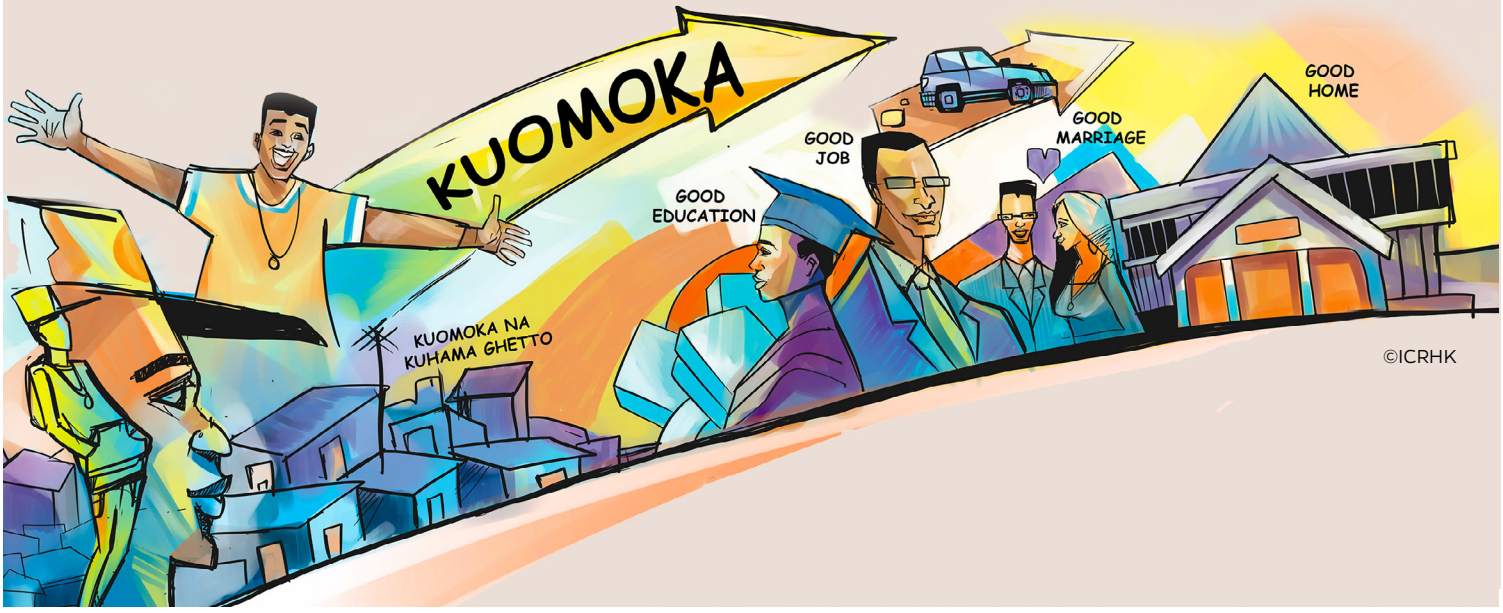
In September 2021, a culminating interagency symposium was held in collaboration with several research and advocacy groups working in Nairobi County to comprehensively address AY empowerment, SRHR, GBV, the impact of COVID-19 on AY, and gender mainstreaming. The convening partners were the African Institute for Development Policy, Africa Population & Health Research Center, Amref Health Africa, Centre for Rights Education & Awareness, International Centre for Reproductive Health Kenya, Jhpiego, The Challenge Initiative, Advance Family Planning, Kenyatta University,

Ministry of Health, Nairobi Metropolitan Services, Population Council, Youth Advisory Council, and Women's Empowerment Link. The inter-organizational virtual symposium brought together researchers, program implementers, advocates, government representatives, and non-government actors from the diverse sectors of gender, education, health, and economic empowerment for adolescents and youth. The symposium provided a platform for sharing findings, providing positive contributions to the topical issues. An important product of this meeting was a set of key recommendations to guide implementation of evidence-based AY programs at the interface of gender, adolescent health including SRH, and recovery from the COVID-19 pandemic. Resulting recommendations addressed policy, programs and advocacy regarding SRH; gender and gendered impact of COVID-19; and COVID-19 innovation and technology. A final symposium report, including resulting recommendations, were shared at the national level. For the event agenda, please see Appendix 2: September 2021 Inter-organization Symposium Agenda.

Policy and Program Initiatives to Support Youth and their Families during the COVID-19 Pandemic

In the immediate wake of the pandemic, several policy initiatives were undertaken to meet the immediate health, economic and social needs, including those of youth.

- Expansion of **social assistance and cash transfer program** for vulnerable households not covered by existing social protection programs (April 2020). According to Doyle and Ikutwa (2021), an EU-funded consortium, led by the Kenya Red Cross Society and Oxfam, expanded support for existing social assistance programs in Kenya. From April–June 2020, nearly $8,000 KES per month were provided to 29,400 vulnerable households in urban informal settlements in Nairobi and Mombasa through this program. Specifically, this effort focused on 10,400 women and girls who are survivors or at risk of SGBV (Doyle & Ikutwa 2021).
- Expansion of **employment opportunities**, particularly for youth (begun April 2020). The Kazi Mtaani National Hygiene Program took a phased approach to employment opportunities to young people (Phase 1: April – June 2020, Phase 2: July 2020 – January 2021) (State Department for Housing and Urban Development 2021; Education News Hub 2021).
  - In the early phases of the COVID-19 pandemic, the Government created the program to create work opportunities for young people to contribute to public sanitation, infection control measures, and public works. Implemented by the State Department for Housing and Urban Development, the program targets young people whose work has been disrupted due to COVID-19, specifically those aged 18-34 and living in urban informal settlements.
  - From April to June 2020, 26,000 young people in eight urban counties, including Nairobi, were provided $600 KES per day, paid weekly, with up to 22 days of labor per month (Ouma 2021; World Bank 2020).
  - The program's second phase, from July 2020 to January 2021, focused more on construction and infrastructure opportunities for more than 340,000 youth in 34 counties (Ouma 2021). Given the expanded scope, work in this phase was capped at a maximum of 11 days per month (Doyle & Ikutwa 2021).



- Support for **pregnant women experiencing emergencies during curfew hours** (begun April 2020). The Nairobi County "Wheels for Life" initiative for pregnant women was created in partnership with Amref Health Africa and Bolt, a transportation mobile application, through the Ministry of Health to offer free transportation services to pregnant women experiencing emergencies during curfew hours (Wangamati & Sundby 2020; Wheels for Life 2021). Wheels for Life also offers free medical advice to expectant mothers (Wangamati & Sundby 2020).
- Direct assistance through **food aid and addressed concerns with food insecurity** (April 2020). Early in the pandemic, direct food distribution sites were created at the national- and county-levels, but faced several challenges, including fatal stampedes at distribution sites and lack of social distancing. To prevent these issues, the government has used digital platforms for individuals to obtain food rations from local vendors. The County Government Coordination and Food Supply Working Group permits agricultural markets to remain open while following proper hygiene and social distancing measures and monitors the availability and affordability of food and water (McDade et al. 2020).
- **Addressed mental health** through interim guidance and expanded services. The **Ministry of Health issued Interim Guidance on Continuity of Mental Health Services During the COVID-19 Pandemic** (Ministry of Health 2020b). The relevant Ministry of Health units developed guidance to ensure mental health services are available during COVID-19 pandemic. To provide mental health and psychosocial support, the Ministry of Health established **a suicide prevention hotline and related tele-counselling and tele-psychiatry services.** This mental health intervention also includes support for individuals struggling with substance abuse. Phone numbers to referral facilities to address COVID-19 related mental health challenges are outlined in the Interim Guidance on Continuity of Mental Health Services During the COVID-19 Pandemic (Ministry of Health 2020b). Befrienders Kenya is a charity organization offering suicide prevention services that has a help line and online support groups (Befrienders Kenya 2021).
- Addressed **GBV** through expanded investments in services (pledged May 2021). In response to the GBV issues presented by the COVID-19 lockdowns, a landmark pledge was announced to expand SGBV supports. In May 2021, President Kenyatta announced a $23 million KES pledge in efforts to combat SGBV by 2022 and an additional $50 million KES by 2026 with the goal of establishing shelters for survivors nationwide, boosting police resources to address crimes related to tender, implementing policies to prevent workplace harassment, and incorporating medical, legal, and psychosocial support for survivors to be included in Kenya's Universal Health Coverage scheme (Bhalla 2021).
- The **Ministry of Health issued Interim Guidance on Continuity of Essential Health Services During the COVID-19 Pandemic** (May 2020). This guidance established counselling and provision of family planning methods, including emergency contraceptives, as essential health services (Ministry of Health 2020a). Antenatal, maternity, postnatal, newborn, and child health services are also considered essential. Under guidance from the Division of Reproductive and Maternal Health, antenatal, labor, and postnatal services are to be supported by county health teams in collaboration with the Ministry of Interior and National Coordination to ensure security. Clinical visits for ANC may be reduced to four face-to-face visits where feasible, supplemented by telephone consultations. Emergency services should include health services and support for sexual and gender-based violence survivors.
- Gaps in **menstrual hygiene management** were gaining recognition and policy momentum prior to the COVID-19 pandemic. In May 2020, the Ministry of Health released the first national Menstrual Hygiene Management (MHM) Policy and Strategy, calling for County Health Departments to create targeted programs and budget line items for MHM (Ministry of Health 2020c). While not directly informed by COVID-19, this guidance is clearly relevant during the COVID-19 pandemic, given the gaps in access identified.

Key Recommendations

Strengthen policy mechanisms that engage adolescents and young adults in responding to COVID-19 and endemic threats to their wellbeing.

- Many of the programmatic and policy priorities established in the immediate wake of COVID-19 have implications for youth and can benefit youth, though ensuring that youth can access and benefit from these programs is essential. This can be accomplished by:
    - Establish a national, multi-agency Adolescent Task Force to develop a framework for an integrated multi-sectoral adolescent resilience and development strategy
    - Establish County Adolescent Multi-Sectoral Working Groups to develop context specific Integrated County Adolescent Action Plans to oversee implementation, monitor progress and reporting of gender-transformational policy and programming
    - Raise adolescent's voices by supporting their participation in all public decision-making, through the COVID-19 response, recovery and beyond.

Prioritize sexual & reproductive health and rights for adolescents and young adults during COVID-19 and beyond

- Ensure comprehensive age-appropriate sexuality education, including very young adolescents as SRH programs for adolescents often target older adolescents, missing a key opportunity to intervene prior to initiation of sexual activity.
- Scale up effective programs to reduce adolescent and teenage pregnancies (For example: Migori–multi-sectoral approach which includes all key players such as Ministry of Education, Ministry of Gender and Youth Affairs, Police, Religious leaders. This has allowed coherent response to adolescents).

- Ensure congruence of legal environment and policies (e.g., right to have access to reproductive health services for all those who require them versus the age when one can make a decision).
- Support holistic programs that buffer against harmful practices, such as teenage pregnancies and early marriages, and advocate for initiatives to keep the girl child in school (For example: The Koota Injena project implemented by Amref Health Africa, which translates to "Come let us talk" in the Borana language (Amref Health Africa 2021). The project promotes the use of community dialogues to end female genital mutilation/cutting (FGM/C) and child, early and forced marriage (CEFM) in 40 communities who identify as Samburu, Borana, Rendille and Gabra in Samburu County and Marsabit County).
- Collaborate with political and other leaders (religious and community) to optimize and/or strengthen capacity to advocate for youth sexuality education including provision of contraception.
- Provide information and youth-friendly services for adolescents and address the prevailing culture of stigma around adolescent sexual activity.

Address mental health for adolescents and young adults during COVID-19 and beyond

- Mental health supports are essential for youth to mitigate the impact of the pandemic, particularly the economic toll to youth themselves and their families.
- Social media is widely used to maintain social connection, making mobile technologies a promising medium through which to deliver mental health services, however gender differences in access must be addressed.
- Implement the interim guidance on continuity of mental health services during the COVID-19 pandemic (Ministry of Health 2020b).

Mitigate the economic and educational impact of COVID-19 for adolescents and young adults

- Supports specific to youth are needed to ensure overall economic viability, and gender equity in both economic stability and access to education.
- Consider poverty reduction strategies alongside SRH services.
    - For adolescents living in slums, poverty constrains the ability to access quality health information and services and may also contribute to coercive sexual relationships, particularly for young women.
- Promote women's economic empowerment initiatives that promote women's financial independence and gender earning parity, through direct assistance coupled with gender norms change for impact.
- Youth development and empowerment programs (such as microfinance, skill building and social groups) are critical for youth during and after the pandemic.
    - Programming must address the unique needs of young women and girls, who face distinct privacy and social constraints due to COVID-19.

Address the GBV risks to adolescent girls and young women, including intimate partner violence, in addition to sexual violence by non-partners

- Advocate for meaningful, evidence-based male engagement to champion against gender-based violence.
- Budget for and implement evidence-based prevention and response programs that address immediate and ongoing risks of gender-based violence exacerbated by COVID-19, and those that existed pre-pandemic.
- Use the existing evidence base to identify priority populations for prevention and access to services.
- Provide and support provision of safe spaces and mentors for adolescents and youth who have suffered from GBV effects within the community, with the necessary training for these lay professionals.

Continue monitoring on gendered impact of COVID-19, particularly among youth, with data feedback loops centered on youth and stakeholders. Use gender-disaggregated and age-disaggregated data to monitor equity and identify unmet needs throughout the COVID-19 pandemic and recovery, and beyond.

- Leverage existing gender-disaggregated and age-disaggregated data to monitor equity and gaps therein.
- Ensure inclusion of gender-disaggregated data county and national levels to guide development and prioritization of activities for youth.
- Advocate for research findings that are gender-disaggregated for purposes of targeted monitoring of indicators.
- Build data literacy capacity and skill among youth mobilization leaders and youth advocates to interpret data and communicate on topics that impact their lives and well-being.

Continue measurement innovation to optimize gender-related measures, including those developed specifically for COVID-19, to ensure that gender metrics are both high-performing and relevant to women's lives.

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Appendix 1: February 2021 Gender in the Pandemic Webinar Agenda

Gender in the Pandemic
The Gendered Impacts of COVID-19: Spotlighting Nairobi Youth Voices and Experiences

Date: February 10, 2021

Time: 9:00-11:00am EST | 5:00pm-7:00pm EAT

Format: Zoom Webinar

Time	Activity
9:00am EST 5:00pm EAT	**Opening remarks** Dr. Michele Decker, ScD, MPH Bloomberg Associate Professor of American Health in Violence Department of Population, Family, and Reproductive Health Johns Hopkins Bloomberg School of Public Health
9:10am EST 5:10pm EAT	**Personal storytelling of the COVID-19 pandemic from Nairobi youth** Presented in partnership with The Stoop Storytelling Series
9:20am EST 5:20pm EAT	**Overview of the global evidence base on the gendered dynamics of COVID-19** Dr. Rosemary Morgan, PhD, Assistant Scientist Department of International Health Johns Hopkins Bloomberg School of Public Health
9:30am EST 5:30pm EAT	**Personal storytelling of the COVID-19 pandemic from Nairobi youth** Presented in partnership with The Stoop Storytelling Series
9:40am EST 5:40pm EAT	**Preliminary results presentation from PMA Gender study on gendered, social and economic impacts of COVID-19 on Nairobi youth and young adults** Dr. Michele Decker, ScD, MPH Bloomberg Associate Professor of American Health in Violence Department of Population, Family, and Reproductive Health Johns Hopkins Bloomberg School of Public Health Dr. Peter Gichangi, PhD, MPH International Centre for Reproductive Health Kenya
9:55am EST 5:55pm EAT	**Personal storytelling of the COVID-19 pandemic from Nairobi youth** Presented in partnership with The Stoop Storytelling Series

Appendix 2: September 2021 Inter-organization Symposium Agenda

Inter-organization symposium in Nairobi, Kenya

Symposium Title: "COVID-19 & beyond: Accelerating use of evidence to maximize opportunities to improve the health and livelihood of AY in Kenya"

Date: September 8 & 9, 2021

Time: 7:00am-11:00am EDT, 2:00pm-6:00pm EAT

Format: Virtual, Zoom meeting

Steering Committee members: African Institute for Development Policy, Africa Population & Health Research Center, Amref Health Africa, Centre for Rights Education & Awareness, International Centre for Reproductive Health Kenya, Jhpiego-The Challenge Initiative & Advance Family Planning, Kenyatta University, Ministry of Health, Nairobi Metropolitan Services, Population Council, Youth Advisory Council, Women's Empowerment Link

DAY 1: INAUGURAL SESSION		
Time (EAT)	**Session**	**Presenter**
	Entertainment from the Youth	All
14:00 – 14:05	Overview of the Symposium	Prof. Peter Gichangi – ICRHK
14:05 – 14:25	Opening Remarks (3 Minutes each) • AY Representative • Academia • Nairobi Metropolitan Services NMS • Secretary, Gender Affairs	• Ms. Martha Kombe – YAC • Prof. Marleen Temmerman – Aga Khan University (AKU) Hospital Nairobi • Dr. Ouma Oluga – NMS • Ms. Faith Kasiva – Gender
14:25 – 14:35	Guest Speaker (10 Minutes)	Dr. Gitahi Githinji – Amref Health Africa
14:35 – 14:45	Official Opening of the Symposium (10 Minutes)	Dr. Andrew Mulwa – MOH
14:45 – 15:00	Keynote Presentation: Value of evidence for decision making (15 Minutes)	Dr. Eliya Zulu – AFIDEP

DAY 1: PRESENTATIONS		
Time (EAT)	**Presentation title**	**Presenter**
Theme 1A:	**Sexual Reproductive Health:** **Chair: Caroline Kabiru (APHRC)** **Co-Chair: Shannon Wood (JHU)**	
15:00 – 15:10	Contraceptive dynamics during COVID-19: Longitudinal mixed methodology study among AY in Nairobi, Kenya	Peter Gichangi – ICRHK
15:10 – 15:20	"I was tricked": understanding reasons for unintended pregnancy among sexually active adolescent girls	Anthony Ajayi – APHRC
15:20 – 15:30	Meaningful youth engagement framework scorecard	Faith Boit – Amref
15:30 – 15:40	Adolescents and youth contribution to unintended births in Kenya	Francis Kundu – NCPD
15:40 – 15:50	What more do advocates need from the data?	Sam Mulyanga – AFP
15:50 – 16:05	**Q & A Session**	All
5 Minutes	**Health Break – Entertainment from Youth**	
Theme 1B:	**Sexual Reproductive Rights:** **Chair: Jean Patrick (MOH)** **Co-Chair: Eva Muluve (Population Council)**	
16:10 – 16:20	"A synopsis of the legal and policy environment for ASRH in Kenya – challenges, opportunities and implications"	Bernard Onyango – AFIDEP
16:20 – 16:30	Re-imagining sexual and reproductive health and rights for adolescents and young people: Trends and perspectives	Korir Kigen – UNFPA
16:30 – 16:40	Using evidence to inform AY targeted intervention-lessons learnt from Migori County.	Lily Njoki – Migori County
16:40 – 16:50	Use of Manyatta model to influence social and behavior change to improve access to family planning andreproductive health services in Samburu County.	Wako Banchale – Amref
16:50 – 17:05	**Q & A Session**	All
5 Minutes	**Health Break – Entertainment from Youth**	
Theme 2A:	**Gender and gendered impact of COVID-19** **Chair: Virginia Nduta (WEL), Co-Chair: Michele Decker (JHU)**	
17:10 – 17:20	Gendered economic, social and health effects of the COVID-19 pandemic and mitigation policies in Kenya: Evidence from a prospective cohort survey in Nairobi informal settle-ments.	Beth Kangwana – Population Council
17:20 – 17:30	Gender dynamics, gender-based violence & safety during COVID-19 outbreak among adolescent & youngadult cohort in Nairobi, Kenya.	Michele Decker – PMA/JHU
17:30 – 17:40	Gendered dimensions of social & economic impact of COVID-19 outbreak among adolescent & young adultcohort in Nairobi, Kenya.	Grace Ngare – KU
17:40 – 18:00	**Q & A Session & vote of thanks**	All

DAY 2: PRESENTATIONS		
Theme 2B:	**Gender and gendered impact of COVID-19** **Chair: Prof Grace Ngare, Co-Chair: Julie Mwabe (Presidential Policy & Strategy Unit)**	
Time (EAT)	**Presentation Title**	**Presenter**
14:00 – 14:10	**Edutainment from the youth**	
14-10 – 14:20	Association of gender-based violence and stressful life events with depression among adolescent girls in Nairobislums	Yohannes Wado – APHRC
14:20 – 14:30	GBV prevention and response (experiences, lessons learnt, gaps and unmet needs for adolescent girls and young women).	Virginia Nduta – WEL
14:30 – 14:40	End term evaluation of Koota Injena Activity ("Promoting abandonment of female genital mutilation/cutting (FGM/C) and child early forced marriage (CEFM) through clan dialogue in Marsabit and Samburu Counties").	Herbert Barasa – Amref
14:40 – 14:50	A LOT Change: Lessons learnt from implementation of the program on adolescent girls and boys in urban Kenya	Benta Abuya – APHRC
14:50 – 15:00	Arising from the shadow of GBV during the Pandemic: Safety net for women and girls.	Elsie Milimu – CREAW
15:00 – 15:15	**Q & A Session**	
5 Minutes	**Health Break – Entertainment from the Youth**	
Theme 3A:	**COVID-19: Innovations & Technology** **Chair: Dr. Meshack Ndirangu (Amref) , Co-Chair: Bianca Devoto (PMA)**	
15:20 – 15:30	The COVID Pivot: adapting data collection to measure the impact of COVID	Elizabeth Gummerson – PMA
15:30 – 15:40	Innovative use of DHIS for enhancing data driven decision making to reduce teen pregnancy in Kenya	Ken Owino & Kirole Ruto – TCI
15:40 – 15:50	Use of digital platform to collect qualitative data: Experiences and lessons learnt from PMA Gender/Covid- 19 study	Mary Thiongo – ICRHK
15:50 – 16:00	Mobile phone data collection – experiences and lessons learnt from the COVID-19 KAP surveys.	Eva Muluve – Population Council
16:00 – 16:10	Managing the new norm: Voices from the youths	U-Tena CBO
16:10 – 16:20	The status of learning at home, challenges and coping strategies during the COVID-19 pandemic: Experiencesfrom two urban informal settlement	Nelson Muhia – APHRC
16:20 – 16:30	Using WhatsApp Chat bot to deliver comprehensive sexual education	Mitchel Kipkurui – Amref
16:30 – 16:45	**Q & A Session**	
5 minutes	**Health Break – Entertainment from Youth**	
Theme 3B:	**COVID-19: Lessons Learnt** **Chair: Paul Nyachae (TCI), Co-Chair: Dr. Griffins Maguro (ICRHK)**	
16:50 – 17:00	Impact of COVID-19 on adolescents in Kenya	Karen Austrian – Population Council
17:00 – 17:10	Use of human centered design in developingcomprehensive sexual education delivery channels (faithbased, edu sport, digital and print comic).	Fidelina Ndunge – Amref
17:10 – 17:20	Lesson learnt in scaling up AYSRH best practices in East Africa: Experiences from 40 cities in Kenya, Uganda andTanzania.	MorineLucy Sirera – TCI
17:20 – 17:35	**Q & A Session**	
CLOSING CEREMONY		
17:35 – 18:00	**Way Forward & Policy implications (5 minutes each)**	
	Theme 1:	Prof Peter Gichangi
	Theme 2:	Prof Grace Ngare
	Theme 3:	Dr. Meshack Ndirangu
	Official Closing of the meeting (NCPD)	**Dr. Sheikh Muhamed**

Appendix 3: Social Media Snapshots

November 2020 Dissemination Event

Livestream coverage from NTV Kenya enabled broad reach to policy, practitioner and lay audiences

- On **Facebook Live** with 10,000 views (4M followers) view here
- On **Twitter** with 2,600 views, in addition to sharing a shorter clip with 1,000 views (2.73M followers) view here
- Shared on **YouTube** with 1,187 views (1.34M subscribers): view here or here

Social media engagement via new hashtag #PMAGender; search here

- **162 tweets** using #PMAGender, 33% original tweets and 67% retweets
- **58 unique Twitter contributors** used #PMAGender
- **421 likes or retweets** using #PMAGender in total
- Potential reach of **2,964,445** users
- Potential impression count of **8,576,561** tweets viewed
- Extensive WhatsApp engagement among Nairobi youth; though harder to follow

#PMAGender audience insights:

- **@NTVKenya**, mainstream media outlet (2.73M followers, 28 average mentions)
- **@Tgithurai**, The Link Empowerment Initiative Githurai, sexual and reproductive health and youth empowerment CBO (367 followers, 19 average engagements)
- **@Afidep**, African Institute for Development Policy (4,62 followers, 10 average engagements)
- **@KombeMartha**, Martha Kombe, President of Nairobi Youth Advisory Council (8,475 followers, 7 average engagements)
- **@Tupange4better**, Tupange for Better Cities, NGO in Kenya, Tanzania, and Uganda working on adolescent SRH (54 followers, 2 average engagements)

Inter-organization Symposium (September 2021)

From 10-16 September 2021, we observed:

- **100 tweets** using #YouthGender-COVID2021, with a peak around Sept 10 with 49 tweets
- **52 unique Twitter contributors** used #YouthGenderCOVID2021
- **95 retweets and 1 reply** using #YouthGenderCOVID2021 in total
- **Potential reach of 83,637 –** which is the projected number of users who may have seen tweets using #YouthGender-COVID2021
- **Potential impression count of 180,226 –** which is the projected number of times that users may have seen tweets using #YouthGenderCOVID2021

#YouthGenderCOVID21 audience insights:

- High level of engagement from feminist and youth advocates: @MugoAngelah (669 followers), @RenciaRed (1,193 followers), @RitahAnindo (3,663 followers), @Alvinmwangi254 (3,720 followers), and @AbukaAlfred (2,788 followers)
- Event co-organizers: @Afidep (5,525 followers), @CREAWKenya (15.8K followers), @Pop_Council (21.7K followers),
- @KombeMartha, Martha Kombe, President of Nairobi Youth Advisory Council (9,390 followers)
- @roseoronje, Rose Oronje, Director, Public Policy & Communications at AFIDEP (4,232 followers)
- @MamaDaktari, Marleen Temmerman, Chair & Director Aga Khan University (6,213 followers)
- @MTotoNews, Digital news media outlet (5,983 followers)
- Other NGO supporters: @KenyaSRHR (9,068 followers) and @WAI_WomenAid (2,023 followers)

PMA | GENDER

PERFORMANCE MONITORING FOR ACTION

ICRH Kenya
INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH

KENYATTA UNIVERSITY

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Bill & Melinda Gates Institute for Population and Reproductive Health