Nairobi Youth Respondent-Driven Sampling Survey: Final Report

PMA AGILE

ICRH Kenya
INTERNATIONAL CENTRE FOR REPRODUCTIVE HEALTH

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List of Tables and Figures

List of Acronyms

DHS	Demographic & Health Survey
EC	Emergency contraception
ICRHK	International Centre for Reproductive Health – Kenya
IQR	Interquartile range
IUD	Intrauterine device
LARC	Long-acting reversible contraception
PMA2020	Performance Monitoring & Accountability 2020
RDS	Respondent-driven sampling
SRH	Sexual and reproductive health
STI	Sexually transmitted infection

Executive Summary

The growing urban population, limited data on reproductive health behaviors, and low levels of contraceptive use have made urban youth and adolescents a key group for sexual and reproductive health services and research. In June-August 2019, PMA Agile, a project within the PMA suite, and the International Centre for Reproductive Health Kenya (ICRHK) conducted the Youth Respondent-Driven Sampling Survey (YRDSS) among unmarried youth aged 15 to 24 years living in Nairobi, Kenya. YRDSS used respondent-driven sampling (RDS) methodology, a chain-based recruitment method in which study participants recruit their peers through numbered coupon distribution. Study "seeds" received coupons from study staff and started recruitment chains, in which subsequent recruits were also provided with up to three coupons each to recruit additional eligible youth into the study.

The goals of the study were to collect information about awareness, use, and procurement of contraception among unmarried adolescents and youth, both female and male, and enable reach into a population and topic that may be otherwise hidden. The survey could be self-administered by participants and asked questions on a range of topics related to sexual and reproductive health including sexual and fertility history, current contraceptive use, current partnerships, and reproductive coercion. The study enrolled 1357 female and male participants at seven sites throughout Nairobi county, for an overall coupon return rate of 82.7%. The data presented are for 1354 participants with limited missing data.

The study found modern contraceptive use estimated at 53% for males and 37% for females in this study, with a strong reliance on male condoms as the participant's current main method (63.5% overall and 91.4% for young men). Use of highly effective, non-coital-dependent methods was more commonly reported among young women (20% reporting implant and 16% reporting injectables as one of their current methods) relative to young men (<2%). Pharmacies and health centers were the main sources of contraceptive methods for both young men and women.

A key area of interest for this study was contraceptive procurement, as it was hypothesized that young people may be obtaining their methods outside of the hospitals or healthcare facilities, or through friends and partners, to avoid being stigmatized by adults working in the healthcare system for using contraception as an unmarried youth. The majority (91%) of young men in the study procured their own contraceptive methods; however, over one-third of young women relied on their partners or another person. Of these young women, over half indicated that they were entirely dependent on their partner or another person to obtain their method. Convenience and partner responsibility factored heavily into dependence on others for contraception.

Adolescent and young adult women in this study reported a range of potential power imbalances within their current partnerships, including pressure to not use and interference in family planning (18%), partner violence (17%), fear of causing trouble (47%), and monetary and other transactions within relationships (86%). These factors can interfere with successful contraceptive use and enable early and unintended pregnancy. Addressing relationship dynamics and agency within relationships is essential to ensuring knowledge, access, and use of modern contraceptive methods, and ensuring women's empowerment and wellbeing as they begin to form partnerships for the first time. Threats to sexual autonomy within partnerships, dependence on others to obtain contraception, and strong reliance on male condoms as one's main contraceptive method could compromise young women's effective use of contraception to prevent early pregnancy and delay childbearing.

In conclusion, the data presented point to gaps in knowledge and behavior among adolescent and youth regarding SRH in Nairobi county. These gaps could be addressed by:

- Addressing stigma and provider bias for young women seeking SRH services;
- Developing and strengthen tailored AYSRH messaging from information sources preferred by youth;
- Improving messaging and acknowledge gaps on consistent condom use;
- Developing communication strategies to share information on method mix and method effectiveness for adolescents and youth;
- Addressing relationship dynamics and agency within relationships; and
- Harnessing the supportive community norms around contraception.

Background

Kenya, like many countries in sub-Saharan Africa, has a burgeoning youth population, many of whom currently live or are moving to urban areas. Urban adolescents and young people have thus become a target group for reproductive health research and services given the population's growing size, limited data on their reproductive health behaviors, and low levels of contraceptive use compared to the general population. Kenya has experienced a steady increase in the national modern contraceptive prevalence rate (mCPR) from 31.5% in 2003 to 53.2% in 2014; mCPR for unmarried sexually active women aged 15-19 years is 49.3% and 64.2% for those aged 20-24 (Kenya National Bureau of Statistics & ICF International, 2015). In Nairobi county, the mCPR is estimated at 58.3%; however, sexual and reproductive health issues for youth persist, such as adolescent pregnancy (Kenya National Bureau of Statistics & ICF International, 2015). According to the 2018 Round 7 PMA2020 national survey in Kenya, 48.2% of females under 18 years ever had sex, but only 13.0% had ever used contraception (PMA2020, 2019).

PMA Agile, a project within Performance Monitoring and Accountability 2020 (PMA2020), sought a means of measuring contraceptive awareness and use among adolescents and youth as they enter a period of probable sexual activity. PMA Agile typically monitors contraception uptake via clinic-based surveys of providers and clients; however, in this age group, it is suspected that youth and adolescents may be procuring contraceptives via other means, making young contraceptors effectively "hidden" to clinic staff and compromising the accuracy of clinic-based survey measures. Capturing information from youth clients of health facilities, especially unmarried females, is challenging due to social and familial pressure to hide sexual activity and contraceptive use. How young females and males procure their methods is not well known and it is assumed their sexual partners, relatives or other adults assist in procurement. Moreover, data on the contraceptive behaviors of adolescent and youth males are not frequently captured in household surveys, leaving the behaviors of this segment of the population hidden, as well.

It is within this context that PMA Agile in collaboration with the International Centre for Reproductive Health-Kenya (ICRHK) conducted a survey of youth aged 15-24 years in Nairobi using respondent-driven sampling (RDS) methodology. This study is a companion study to the pilot YRDSS that was conducted in Abidjan, Côte d'Ivoire in 2018 (AIBEF & PMA Agile, 2019).

The present study aims to inform about awareness, use, and acquisition of contraception among both female and male unmarried youth and adolescents in Nairobi and enable reach into a population and topic that may be otherwise hidden.

The primary objective of the study was to determine awareness, usage and source of contraception among unmarried aged 15-24 years in Nairobi county while specific objectives were:

1. To estimate the percent of 15-24-year-old unmarried females and males aware of different methods of contraception
2. To estimate the percent of 15-24-year-old unmarried females and males using contraceptive methods
3. To understand the sources of and consumption patterns of contraceptive methods among unmarried females and males aged 15 to 24 years

About PMA & PMA Agile

Performance Monitoring for Action (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. PMA Agile is a separate but related three-year grant that was developed to capitalize on PMA and build a monitoring and evaluation platform for large-scale projects that will enable near-continuous tracking of family planning (FP) performance and progress toward their intended results. PMA Agile tracks change at the health system level through quarterly public and private health facility audits and periodically through the conduct of client exit interviews about contraceptive behaviors. PMA Agile is operational in six countries in Africa and Asia, including Kenya, working through local university and research organizations with the aim of building local capacity.

About the International Centre for Reproductive Health Kenya (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 18 years, ICRKH has partnered with various organizations to implement high-quality sexual and reproductive health (SRH) programs.

Scope of work

Over 18 years, ICRHK has designed and implemented 50 intervention studies and research in the area of sexual and reproductive health. Specifically, this covers: HIV/AIDS prevention and care among key populations (female sex workers, men who have sex with men, and transgender people); HIV/AIDS prevention among adolescents and young women; oral pre-exposure prophylaxis among key populations and among adolescent girls and young women; maternal and child health and family planning; sexual and gender based-violence prevention and treatment; and commercial sexual exploitation of children. ICRHK is also implementing a measurement program to track FP indicators and other program interventions.

ICRHK has a balanced program between basic research and operations research on one side and implementation of best practices and experiences on the other. These studies and projects are implemented with funding from a variety of international organizations and agencies, including the WHO, EDCTP, USAID, Bill and Melinda Gates Foundation, ANRS, UNFPA, IPM, EU. ICRH has been a WHO collaborative centre on reproductive health since 2004.

Geographical coverage

Most of ICRHK's work is in the Coastal area of Kenya. From 2000 to 2014, ICRHK projects were within Mombasa, Kwale, Taita Taveta and Kilifi counties. From 2014, ICRHK expanded to the following counties: Nairobi, Kitui, Nyamira, Siaya, Kericho, Uasin Gishu, Kiambu, Migori, Bungoma, and Nandi. In 2016, ICRHK added Migori, Uasin Gishu, Kakamega and West Pokot counties, with short-term activities in Homa Bay and Narok counties. Currently, ICRHK's work covers 16 of the 47 counties in Kenya.

Methods

Design

From 21 June 2019 to 14 August 2019, PMA Agile and ICRHK conducted a study among unmarried adolescents and youth aged 15 to 24 years living in Nairobi, Kenya. The study utilized respondent-driven sampling (RDS), a chain-based recruitment method, given feasibility concerns for household- and clinic-based sampling for this study population. RDS is premised on the assumption that peers are better able to locate and recruit other members of a hidden population than health facility or research staff. Thus, RDS surveys have been widely used for hard-to-reach populations, including men who have sex with men, people who inject drugs, and homeless youth. While typically indicated for hidden populations, RDS is similarly valuable for hidden behaviors. In settings where sexual activity and contraceptive use among adolescents are intentionally hidden due to social and familial pressure, RDS can be a valuable means of recruiting adolescents for survey and intervention research on this hidden topic.

The study began with a formative research phase in March 2019, which included focus group discussions with youth, youth organization leaders, and local stakeholders to solicit input on study feasibility and network subpopulations of interest. Focus groups with youth were conducted at five sites throughout the city to explore RDS acceptability, sensitivity of survey question themes, and interest in the study among this target population. We characterized youth network properties including subgroupings and the level of networking within and across subgroupings, identified necessary seed characteristics, and refined survey domains, consistent with formative RDS recommendations (Johnston, 2008, 2010).

All the study sites were officially closed between 27 August and 6 September after ICRHK staffs had close-out meetings with the site managers in the sites.

Sample

The target sample size of the study was 1300 participants.[1] Eligible seeds and participants were unmarried adolescents aged 15-24 years who have resided in Nairobi for at least one year. Seeds were purposefully selected to serve as the initial contacts for recruiting from the target population through short interviews conducted by ICRHK ahead of study launch.

[1]This is based on the observed modern contraceptive prevalence rate of 17.4% among unmarried females 15 to 24 years of age in PMA2020/Nairobi. The simple random sample size required for a +/- margin of error of 3% points is 614. The estimated design effect (DEFF) is 2, which results in an effective sample size of 1228. With a 5% field recruitment error rate, the target sample size is 1293, which we have rounded to 1300.

Seeds were identified by staff through personal networks and by the partner community-based organizations (CBOs) through their youth networks. Seed characteristics included sex, age, subcounty in Nairobi, level of schooling, and current school status (in-school or out-of-school). Seven seeds were launched on June 21-22 (5 females, 2 males), one male seed was launched on July 10, and one male seed was launched on July 31, for a total of nine seeds. After selection and enrollment of initial seeds, recruitment of the target sample size was achieved through peer-to-peer coupon distribution. The two male seeds that were launched after initial study launch in June were selected with the goal of improving male participant recruitment.

Data Collection Tools

Participants completed an anonymous survey that focused on eight main areas related to youth sexual and reproductive health: demographic information; fertility preferences; contraceptive knowledge; general sexual history; current partnerships and sexual activity; contraceptive use; relationship behaviors; myths, attitudes, and norms related to contraception; and social influence. For questions related to current use of contraception, participants could report the method(s) that they or their current/most recent partner, if they reported that they had a partner, was/were currently using. Participants reported for themselves or on behalf of their partners. All responses were self-reported except participant age, which was verified by study staff using the participant's photo identification to ensure that the participant met the age eligibility requirement.

To maximize confidentiality and minimize bias, the survey could be self-administered via a handheld tablet, which has been demonstrated to enhance accuracy in reporting on sensitive topics among many populations (Ghanem KG, 2005). Staff assistance and/or staff administration of the questionnaire was also available in cases of limited literacy, difficulty comprehending the questions, or unfamiliarity with use of a tablet. If the participant opted to self-administer the questionnaire, a member of the study staff was always present in the room to answer questions.

Participants self-reported the size of their social network to account for potential bias due to differences in selection probability for participants with larger versus smaller networks as required for RDS implementation. To improve accuracy (Johnston LG M. M., 2008), network size questions were asked sequentially and structured to ensure reciprocity in social ties. The sequence was: how many youth between age 15 and 24 who are unmarried and live in Nairobi, 1) do you know personally (know their names), 2) do you know who also know you, 3) do you know who know you and whom you have seen or spoken to at least once in the past six months, with the final question serving as the participant's network size. This sequence of questions was always administered by an interviewer to allow for explanation and further probing given the specificity of the questions.

The survey was developed in English, professionally translated into Swahili, and piloted with native speakers to ensure comprehension. Discrepancies were resolved through an iterative process. Participants could opt to take the survey in either language. All interviewers were fluent in both languages.

Implementation & Study Procedures

Participant enrollment and data collection took place at seven sites located throughout the city in the following sub-counties: Dagoretti North, Embakasi East, Kamukunji, Kibra, Makadara, Roysambu, and Ruaraka. Study sites were located within youth-friendly clinics and community-based organizations that carry out programs aimed at youth.

When a seed or recruit presented for data collection, staff first verified coupon validity and assessed the participant's eligibility. Staff also scanned the recruit's fingerprint to ensure that s/he had not already participated in the survey. Fingerprint scanning was used in this study to prevent duplicates, especially given that the study had multiple sites and staff from one site would not know who enrolled at another site. Consent was conducted in a private space; parental consent for minors under age 18 was waived for this study, as it was considered low risk and parental involvement may have dissuaded participant enrollment or influenced participant responses.

Following informed consent, participants were oriented to the survey procedures. After survey completion, consistent with RDS methods (Magnani R, 2005), seeds and subsequent recruits were provided with up to three recruitment coupons each to recruit additional youth into the study until recruitment goals were reached. Each coupon had an expiration date, after which it could not be redeemed. Coupon expiration dates were used to control recruitment pace and to end recruitment when the sample size was achieved. Coupons were identifiable by sequential numbers which linked recruits to their recruiters, enabling creation of recruitment chains. Coupon data were input into electronic coupon manager

forms, which were uploaded and monitored daily for duplicate coupons and missing referral linkages. All coupons included a coupon number, barcode of the corresponding coupon number, and a referral number that linked the participant with their recruiter. Coupons also included a map and address of the study site, study hours, site phone numbers, and a description of study eligibility criteria.

After survey completion, participants received a primary compensation of 500 KES (approximately US$5) to compensate them for their time and participation and 500 KES for transport reimbursement. Prior to their departure from the study office, participants received a short explanation about coupon distribution from study staff and were informed that they could receive a secondary compensation of 300 KES (approximately US$3) per recruit if they successfully distributed coupons to eligible participants who came to the office and completed the study. Participants received a one-page recruitment script to take with them that outlined this information. All participants were also given a coupon stub that included their own coupon number and the coupon number(s) of their recruit(s) to reference if they called the study site to inquire about their recruits. All compensation was distributed using M-Pesa, a mobile phone-based money transfer system, so participants did not need to return to a study site to collect their secondary incentive. Appropriate amounts for compensation were discussed with ICRHK staff and youth focus group members prior to study launch.

Procedures to ensure data quality included a staff-monitored data collection room and participant notification at enrollment that they would not receive recruitment coupons if they appeared to complete the survey haphazardly. Rate of non-response by respondent was monitored throughout the data collection period.

To taper participant enrollment, coupon distribution was reduced to one outgoing coupon per participant on July 18 and ended on July 29 for recruitment chains originating from seeds 1-8. Coupon distribution ended on August 3 for the seed 9 recruitment chain.

Ethical Review

All study procedures were approved by Institutional Review Boards at Johns Hopkins Bloomberg School of Public Health and the Ethical Review Committee at Kenyatta National Hospital/University of Nairobi.

Results

All results presented are from the PMA Agile/ICRHK Youth Respondent-Driven Sampling Survey in Nairobi. The following table and figures illustrate the study enrollment pace and coupon distribution, a key element of RDS implementation. Overall, 1674 coupons were issued, including coupons for 9 seeds, of which 1384 (82.7%) were returned within their validation period. Of participants who returned valid coupons, 98.1% were deemed eligible to participate and 100% of these participants consented to be in the study. The final analytic sample came to 1354 after 3 participants were excluded for excessive missing data.

Table 1. RDS implementation parameters (metrics)	
Coupons issued (including seeds)	1674
Coupons returned outside of validation period (after expiration date)	36
Coupons returned within validation period (including seeds)	1384
Coupon return rate within validation period (returned/issued)	82.7%
Eligible participants/coupons returned	1357 (98.1%)
Consented/eligible	1357 (100.0%)
Included in analysis for minimal missing data	1354 (99.8%)
Number of recruits by seed (mean, range)	157.8 (4-245)
Number of recruitment waves per seed (mean, range)	7.4 (2-10)

Figures 1-4 show enrollment patterns for the entire study period. These metrics were monitored closely to ensure enrollment remained on target as well as to ensure an equal gender mix.

Figure 1. Overall daily enrollment

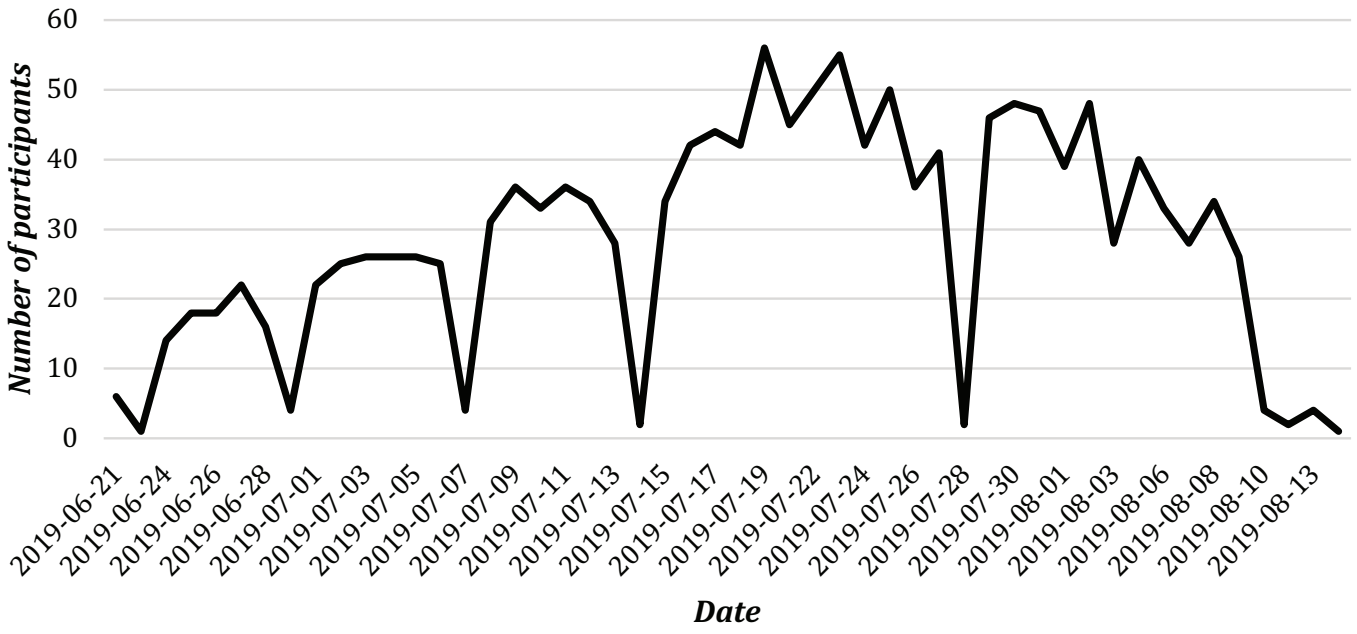


Figure 2. Daily enrollment by gender

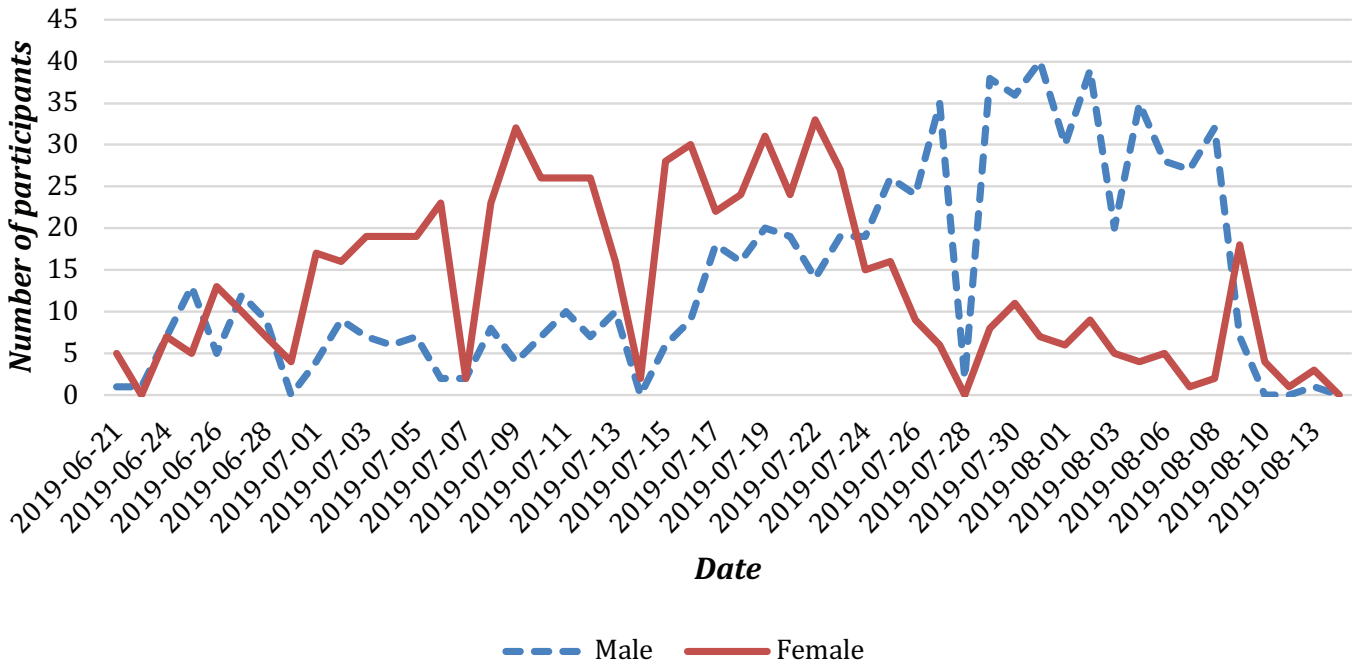
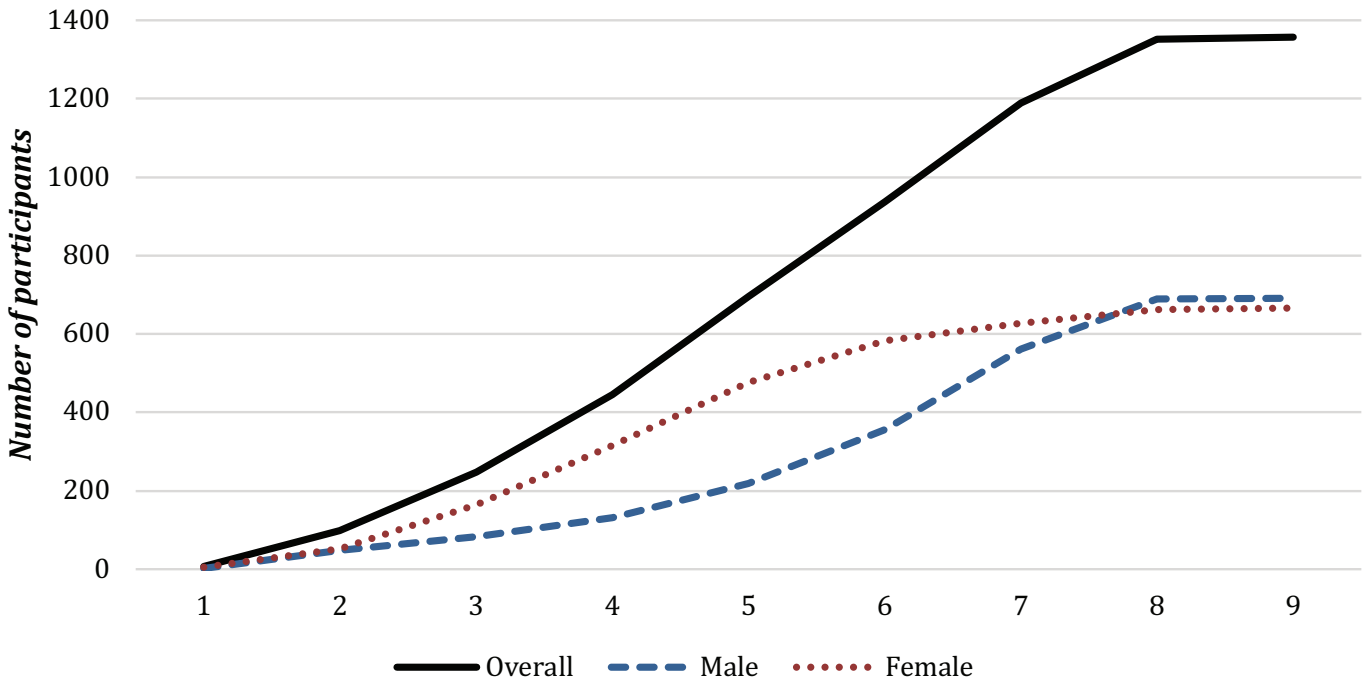


Figure 3. Cumulative weekly enrollment overall and by gender

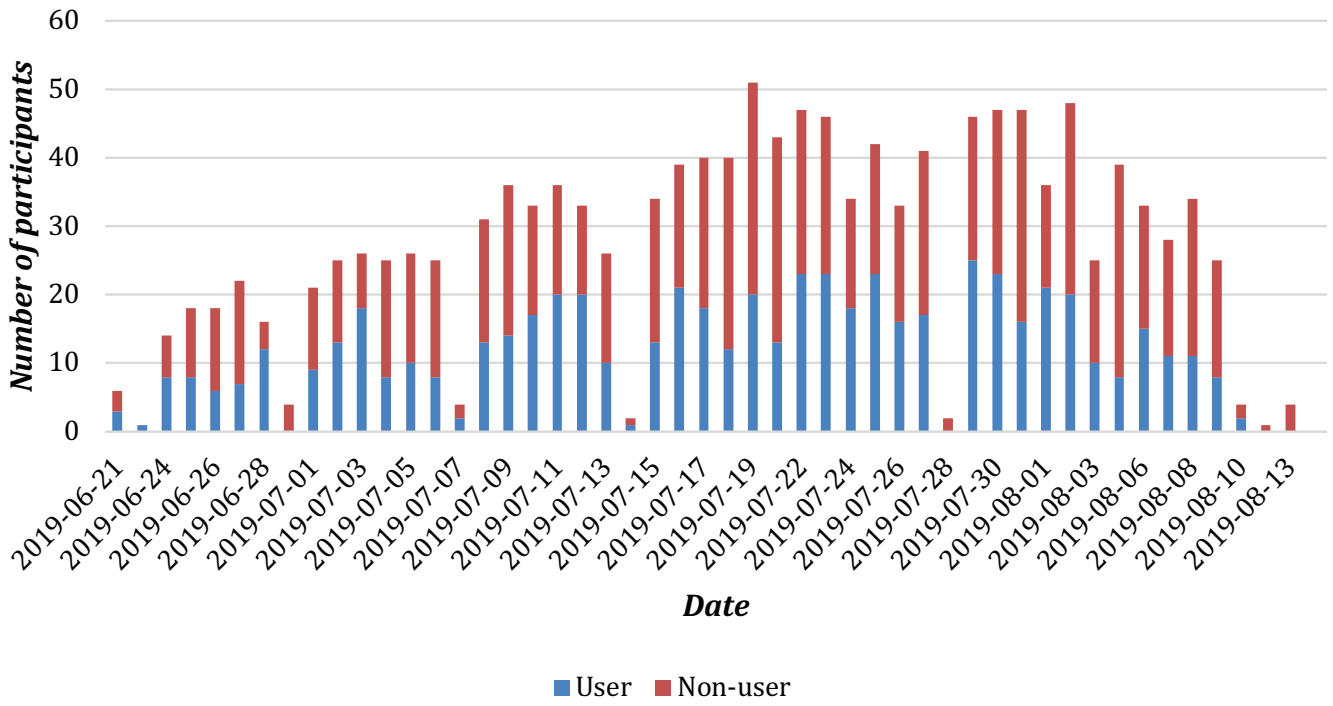


Female enrollment occurred more rapidly than male enrollment. Female participants were slightly more likely to distribute coupons to another female – 56% of female participants gave a coupon to a female recruit compared to 44% who gave a coupon to a male recruit [Table 2]. A higher percentage of male participants distributed coupons to recruits of the same sex, but this may have been influenced by a push towards the end of the study to increase male enrollment [Table 2; Figure 2].

Table 2. Transition matrix by gender

	Male	Female
Male	63.3%	36.6%
Female	43.8%	56.2%

Figure 4. Daily enrollment by participant's reported use of modern contraception



In examining coupon distribution by modern contraceptive use, current users were equally as likely to distribute a coupon to a non-user as to a user, while non-users were more likely to distribute a coupon to another non-user [Table 3]. Current use of a modern contraceptive method is based on self-report. From Figure 4, daily enrollment of user and non-user of contraception appears balanced. This enrollment pattern was analyzed after study completion and was not a factor in coupon distribution.

Table 3. Transition matrix by participant's self-reported use of modern contraception

	Non-user	User
Non-user	64.9%	35.1%
User	50.4%	49.6%

Data Weights

The sample was weighted to accommodate the RDS design. Weights were generated using the RDS-II (Volz-Heckathorn) estimator to account for differences in reported network size of participants and therefore the participant's likelihood of receiving a coupon. Using data from the 2014 DHS, a postestimation weight was developed and combined with the RDS weight to account for differences in demographics (age and education level) in the sample as compared with the underlying population of unmarried adolescents and youth in Nairobi measured in household-based surveys. Unless otherwise indicated, all final results in Tables 5-16 are fully weighted using RDS-II and post-estimation weights. In this sample, female respondents reported smaller network sizes on average (mean network size for females = 11.4; mean network size for males = 23.9) and therefore females are weighted more heavily using the RDS weights.

Demographic Information

The final analytic sample proportion is 664 females and 690 males (1354 total). After weighting, the percentage of males and females came to 41.6% and 58.4%, respectively. Approximately one-fifth of sample participants (20.5%) were 15-17 years old, 43.3% were 18-20 years old, and 36.2% were 21-24 years old; after weighting, the distribution skewed older with 45.4% of participants between 21 and 24 years old [Table 4].

Nearly all participants had attended formal schooling and education levels were similar by sex; however, a higher proportion of males had attended university (20.5% vs. 12.9% of females), while more females reported secondary school as their highest level of education (57.5% vs. 50.9% of males). Participants came from all subcounties of Nairobi, with the highest proportion reporting residence in Dagoretti North (11.4%) and Roysambu (9.8%) (not shown in table).

About one-third of the adolescents and youth came from families that owned the plot (land) where their house is located while another third came from homes made of iron sheets [Table 4].

Table 4. Demographic characteristics

	Overall (N=1354)			Males (N=690)		Females (N=664)	
	W%	U%	N	W%	N	W%	N
Sex							
Male	41.6%	51.0%	690	--	--	--	--
Female	58.4%	49.0%	664	--	--	--	--
Age group							
15-17 years	20.7%	20.5%	278	15.9%	182	24.1%	96
18-20 years	33.9%	43.3%	586	33.8%	285	34.0%	301
21-24 years	45.4%	36.2%	490	50.4%	223	41.9%	267
Highest level of education attended							
Never attended	0.01%	0.4%	5	0.0%	2	0.01%	3
Primary	20.1%	8.2%	111	20.6%	52	19.7%	59
Post-primary	0.6%	0.4%	5	0.7%	2	0.5%	3
Secondary / 'A' level	54.8%	60.3%	817	50.9%	413	57.5%	404
College (Middle level)	16.0%	21.9%	296	20.5%	149	12.9%	147
University	8.5%	8.8%	119	7.1%	71	9.5%	48
No response	0.1%	0.7%	1	0.3%	1	0.0%	0
Home structure							
House	6.0%	4.7%	63	4.8%	38	6.9%	25
Bungalow house	3.9%	4.6%	62	4.8%	38	3.2%	24
Apartment / Flat	14.7%	18.3%	248	18.0%	140	12.3%	108
Plot	36.3%	39.4%	533	38.8%	289	34.6%	244
Iron sheet house	33.7%	27.3%	370	30.4%	150	36.0%	220
Mud house	4.6%	4.9%	66	2.5%	30	6.1%	36
Wooden house	0.7%	0.7%	10	0.5%	4	0.8%	6
Fabricated containers	0.1%	0.2%	2	0.3%	1	0.1%	1
Does not have a home	0.0%	0.0%	0	0.0%	0	0.0%	0

*U%: Unweighted percent *W%: Weighted percent

Sexual Experience and Fertility History

Over two-thirds (70%) of respondents reported that they had ever had sex, with approximately the same percentage of males and females reporting prior sexual activity [Table 5]. Median age at first sex was about one year later for females (17 years) than for males (16 years). Among all female respondents, 30.0% had ever been pregnant, including those who report being currently pregnant, while 15.8% males reported ever had a pregnant partner or have a partner who is currently pregnant. Disaggregating pregnancy by age shows that 13.4% of adolescent girls aged 15-19 have ever been pregnant, compared to 43.2% of young women aged 20-24. Over one-quarter of females (27.3%) and 8.4% of males reported having given birth or having a child. Though the differences between reported ever pregnancy and giving birth are not large, it points to pregnancy losses more for the males (15.8% ever pregnant vis-à-vis 8.4% giving birth). The largest proportion of respondents of both sexes reported that they want to wait 4-6 years before having a child while less than 2% wanted a pregnancy now or soon. These respondents include those who may have a child or children already.

Table 5. Sexual and fertility history among all respondents

	Overall		Males		Females	
	W%	N	W%	N	W%	N
	(N=1354)*		(N=690)		(N=664)	
Ever had sex	70.3%	965	70.2%	478	70.4%	487
Ever pregnant (females) or ever partner pregnant (males) among all respondents	24.0%	272	15.8%	85	30.0%	187
Among respondents aged 15-19 years (n=640)	11.1%	56	7.4%	23	13.4%	33
Among respondents aged 20-24 years (n=714)	33.3%	216	20.9%	62	43.2%	154
Ever given birth *(females)*/have a child *(males)*	19.4%	208	8.4%	39	27.3%	169
Desired wait time before (next) child						
Soon / Now	1.2%	23	2.2%	17	0.5%	6
< 1 year	1.9%	21	2.1%	9	1.8%	12
1-3 years	21.0%	229	24.2%	104	18.8%	125
4-6 years	32.7%	441	29.5%	195	34.9%	246
7-9 years	10.1%	157	10.5%	82	9.9%	75
≥ 10 years	17.7%	301	19.6%	197	16.3%	104
Cannot get pregnant/cause a pregnancy	0.3%	1	0.8%	1	0.0%	0
Other / Don't know / No response	15.0%	181	11.0%	85	17.9%	96
	(N=965)**		(N=478)		(N=487)	
Age at first sex in years [median, IQR***]	17 (15-18)		16 (15-18)		17 (16-19)	

*All respondents **Sexually active respondents ***IQR: Interquartile range

Current Partnerships

The survey asked questions related to the respondent's current or most recent partner, which was reported by 82% of males and 79% of females. About one-fifth (20.8%) of males reported dating or having sex with someone else while dating their current/recent partner, compared to 9% of females. For males, their partners tended to be younger than themselves, about 2 years younger on average, while females reported slightly older partners, about 3 years older on average. Nearly three-quarters of female respondents reported having a current or recent partner that is 2 or more years older than them at the time of the survey, while only 3.6% of males reported having a partner 2 or more years older [Table 6].

Table 6. Characteristics of partnerships among all respondents and respondents in a current/recent relationship

	Overall		Males		Females	
	W%	N	W%	N	W%	N
	(N=1354)		**(N=690)**		**(N=664)**	
Has a current/recent partner	80.0%	1123	81.9%	571	78.7%	552
Involved in concurrent relationships	14.0%	217	20.8%	144	9.1%	73
	(N=1109)*		**(N=559)**		**(N=550)**	
Age of current/recent partner in years [median, IQR] years	21 (19-24)		19 (17-20)		23 (21-25)	
Age difference between partners in years [median, IQR]	1 (-1 – 3)		-2 (-3 – -1)		3 (1 – 4)	
Has a partner 2 or more years older	42.3%	429	3.6%	22	71.1%	407

*Has current/recent partner and reported partner age

Contraceptive Knowledge and Information Sources

Nearly all respondents (98.5%) had heard of at least one method of contraception, 88.7% felt that they can access contraception information, and 84.1% reported knowing a place where they can obtain a method of contraception. These figures did not differ significantly by sex. In addition, almost two-thirds of male respondents (64.5%) and slightly over half of female respondents (51.1%) had heard of pills that can cause an abortion [Table 7].

While respondents reported a range of people in their lives who served as sources of contraception information, healthcare providers, like doctors and nurses, were the most preferred source of information for the largest proportion of respondents (21.7%), followed by their mothers (17.8%), and health centers (11.3%). Mothers were the preferred source of information for young women (27.5%), followed by doctors/nurses (24.7%) and health centers (10.1%). For young men, doctors/nurses were the most important source of information (17.4%), followed by health centers (13.0%) and friends (11.7%) [Table 7].

Table 7. Family planning knowledge and information sources among all respondents

	Overall (N=1354)		Males (N=690)		Females (N=664)	
	W%	N	W%	N	W%	N
Has heard of at least one contraceptive method	98.5%	1336	99.1%	684	98.1%	652
Has heard of abortion pill	56.7%	804	64.5%	445	51.1%	359
Can access contraception information	88.7%	1208	86.7%	605	90.1%	603
Knows a place to obtain contraception	84.1%	1163	83.1%	574	84.8%	589
Preferred source of information on contraception						
Mother	17.8%	195	4.0%	42	27.5%	153
Father	4.1%	53	9.9%	53	0.0%	0
Sister(s)	2.2%	28	0.3%	5	3.5%	23
Brother(s)	1.0%	21	2.2%	20	0.2%	1
Other family member(s)	1.1%	10	0.9%	4	1.2%	6
Partner / Boyfriend / Girlfriend	1.8%	24	3.8%	22	0.4%	2
Friend(s)	9.9%	132	11.7%	81	8.7%	51
Doctor / Nurse	21.7%	274	17.4%	100	24.7%	174
Pharmacist / Shopkeeper	0.6%	7	0.8%	5	0.4%	2
Community health volunteers	2.5%	50	2.5%	24	2.6%	26
Teacher	4.9%	70	7.8%	48	2.9%	22
Religious leader / Church / Mosque	1.2%	17	1.5%	14	1.0%	3
Youth center	9.4%	163	9.2%	98	9.5%	65
After school program	0.8%	15	0.8%	10	0.8%	5
Health center	11.3%	127	13.0%	58	10.1%	69
Health fair or forum	2.0%	42	1.8%	16	2.2%	26
Books / Magazines	0.8%	12	0.8%	7	0.8%	5
Films / Videos	0.1%	4	0.3%	3	0.0%	1
Radio / TV	0.9%	15	1.7%	12	0.3%	3
Internet / Web	2.2%	37	2.8%	26	1.9%	11
Social media (Facebook, Twitter, etc.)	2.3%	33	4.6%	25	0.6%	8
SMS, Whatsapp	0.8%	18	1.4%	13	0.4%	5

Other	0.1%	1	0.1%	1	0.0%	0
No one	0.2%	3	0.3%	1	0.1%	2
Don't know / No response	0.4%	3	0.5%	2	0.2%	1

The survey asked respondents to select all contraceptive methods that they had heard of, and respondents were then asked subsequent questions about the efficacy of a certain method in comparison to another. The respondent had to have heard of both methods in the question in order to receive it. Of respondents who reported that they had heard of both condoms and IUD, 28.9% of males and 46.3% of females correctly identified that the IUD is more effective in preventing pregnancy. Between condoms and oral contraceptive pills, 30.5% of males and 44.7% of females correctly identified that pills are more effective. About one-third of males and females identified that injectables are more effective than standard days method out of 49 respondents who had heard of both of these methods. Finally, nearly 90% of all respondents who had heard of emergency contraception (EC) knew that it is effective when taken within 72 hours of unprotected sex [Table 8].

Table 8. Knowledge of comparative efficacy among contraceptive methods

	Overall		**Males**		**Females**	
	W%	N	W%	N	W%	N
	(N=502)		**(N=152)**		**(N=350)**	
Provided correct response to: "Between these two choices, which is more effective in preventing pregnancy: condoms or coil/IUD?"*	42.3%	191	28.9%	43	46.3%	148
	(N=723)		**(N=298)**		**(N=425)**	
Provided correct response to: "Between these two choices, which is more effective in preventing pregnancy: oral birth control pills or condoms?"*	40.0%	272	30.5%	90	44.7%	182
	(N=49)		**(N=21)**		**(N=28)**	
Provided correct response to: "Between these two choices, which is more effective in preventing pregnancy: injectables or standard days / cycle beads?"*	34.6%	35	32.6%	14	35.4%	21
	(N=808)		**(N=365)**		**(N=443)**	
Provided correct response to: "Emergency contraception (P2) is effective if taken: within 72 hours (3 days) after unprotected sex."*	89.8%	727	89.8%	324	89.8%	403
	(N=1354)		**(N=690)**		**(N=664)**	
Responded YES to: "If a person does not use any method of contraception the FIRST time he/she has sex, can it lead to a pregnancy?"	83.3%	1166	84.9%	594	82.2%	572
"On a scale from 0 (no chance) to 100 (absolute chance), what do you think are the chances of getting pregnant or causing a pregnancy after one single act of unprotected sex?" [median, IQR]	80 (50-99)		70 (50-99)		88 (50-100)	

*To receive these questions, the respondent had to have reported earlier that s/he had heard of all methods mentioned in the question. For example, the respondent needed to select both condoms (either male or female) and IUD in the question, "Which methods have you heard of?", to receive the first question in this table.

The survey also asked respondents about condom use related to HIV prevention and concern about contracting HIV and STIs. Among sexually active respondents, 40.1% overall reported that they "always" use condoms to prevent HIV or STIs; however, there is a large discrepancy between "always" use as reported by males (55.8%) and females (28.8%). Respondents of both sexes reported a high level of concern about contracting HIV or other STIs: 84.2% of males and 82.7% of females reported feeling "very concerned" [Table 9].

Table 9. HIV prevention and concern among sexually active respondents

	Overall (N=965)*		Males (N=478)		Females (N=487)	
	W%	N	W%	N	W%	N
How often did/do you use condoms to prevent HIV or other sexually transmitted infections?						
Always	40.1%	372	55.8%	230	28.8%	142
Most of the time	17.3%	191	24.3%	122	12.3%	69
Sometimes	16.5%	148	9.3%	56	21.7%	92
Rarely	15.1%	145	6.0%	40	21.6%	105
Never	9.9%	99	4.2%	26	14.0%	73
No response	1.1%	10	0.4%	4	1.6%	6
How concerned were/are you that you might catch HIV/AIDS or another sexually transmitted infections?						
Very concerned	83.3%	789	84.2%	383	82.7%	406
Somewhat concerned	8.7%	103	10.4%	64	7.5%	39
Not concerned	7.0%	61	4.7%	27	8.7%	34
No response	0.9%	12	0.7%	4	1.1%	8

*Sexually active respondents

Contraceptive Use

Among all respondents, 60.2% had ever used a contraceptive method and 45.2% reported that they were currently using a method at the time of the survey. Males were more likely to be ever or current users (61.7% and 53.8%, respectively) than females (59.1% and 39.0%) [Table 10]. A participant was considered a current modern contraceptive user if any of his or her reported current methods included IUD, implant, injectables, pills, EC, male condoms, female condoms, or cycle beads. In this population of young women, modern contraceptive prevalence was estimated at 37.2% (95% CI: 32.0%–42.7%).

Participants were asked to select all methods that they and/or their partner, if they reported a partner, were "currently" using. The most common method reported by both males and females was male condoms, although male condom use was nearly double among male respondents compared to females (95.0% of males vs. 44.5% of females). The second most common method reported by males was EC, accounting for 11.4% of current users, followed by withdrawal at 10.9% of current users. Other commonly reported methods for females included long-acting reversible contraceptive (LARC) methods like implants (20.3%) and injectables (16.3%), as well as EC (16.0%).

Participants were then asked to select the method that they use "most of the time", or that they would consider their main method. For male respondents, male condoms were overwhelmingly the main method reported (91.4%). Male condoms were also the most commonly reported main method for female users (36.1%), but longer acting, more effective methods like implants (18.4% of users)

and injectables (15.2% of users) contributed to about one-third of the method mix among female users. Among respondents who reported not currently using a method and having had sex in the past three months, most said that they intend to use a method in the future (85.2% overall).

Table 10. Contraceptive use

	Overall		Males		Females	
	W%	N	W%	N	W%	N
	(N=1354)		(N=690)		(N=664)	
Ever user	60.2%	823	61.7%	409	59.1%	414
Current user	45.2%	619	53.8%	345	39.0%	274
Current user (modern method)	43.6%	593	52.7%	335	37.2%	258
Current user (LARC method)	5.9%	72	1.3%	14	9.1%	58
	(N=965)*		(N=478)		(N=487)	
Used a contraceptive method at first sex	64.3%	642	65.7%	316	63.4%	326
Used a contraceptive method at last sex	77.1%	749	79.2%	369	75.5%	380
Use of emergency contraception in past 12 months (by participant or partner)	33.2%	3741	30.0%	170	35.5%	204
Current method(s) (select all that apply)	(N=619)**		(N=345)		(N=274)	
Implant	11.1%	65	1.8%	11	20.3%	54
Intrauterine device (IUD)	1.9%	7	0.6%	3	3.1%	4
Injectables	8.8%	47	1.2%	8	16.3%	39
Oral contraceptive pills	5.6%	29	3.5%	7	7.6%	22
Emergency contraception	13.7%	112	11.4%	57	16.0%	55
Male condom	69.5%	441	95.0%	321	44.5%	120
Female condom	4.9%	45	6.0%	28	3.8%	17
Cycle beads	0.03%	1	0.1%	1	0.0%	0
Standard days / Safe days / Rhythm	6.1%	47	6.8%	26	5.4%	21
LAM / Exclusive breast feeding	0.0%	0	0.0%	0	0.0%	0
Withdrawal	9.2%	74	10.9%	49	7.6%	25
Herbal pill method	1.4%	5	0.0%	0	2.8%	5
Other method	0.4%	2	0.7%	2	0.0%	0
Don't know	0.3%	1	0.5%	1	0.0%	0
No response	0.3%	2	0.1%	1	0.4%	1
Current main method (select one)						
Implant	9.7%	55	0.8%	4	18.4%	51
Intrauterine device (IUD)	1.6%	4	0.0%	0	3.1%	4
Injectables	7.9%	41	0.4%	4	15.2%	37
Oral contraceptive pills	2.5%	16	0.0%	0	4.9%	16
Emergency contraception	6.0%	39	1.9%	11	10.1%	28
Male condom	63.5%	395	91.4%	298	36.1%	97

Female condom	1.0%	9	0.0%	0	2.1%	9
Cycle beads	0.0%	0	0.0%	0	0.0%	0
Standard days / Safe days / Rhythm	3.2%	20	2.0%	6	4.2%	14
LAM / Exclusive breast feeding	0.0%	0	0.0%	0	0.0%	0
Withdrawal	2.9%	30	2.4%	18	3.5%	12
Herbal pill method	0.9%	4	0.0%	0	1.8%	4
Other method	0.2%	1	0.4%	1	0.0%	0
Don't know / No response	0.7%	5	0.7%	3	0.6%	2
	(N=128)***		(N=54)		(N=74)	
"Do you think you will use a contraceptive method to delay or avoid getting pregnant at any time in the future?" among current non-users	85.2%	109	87.3%	54	84.3%	74

*Sexually active respondents **Current contraceptive users

***Current non-users who have had sex in the past 3 months

Among participants that reported currently using a modern method of contraception (implant, IUD, injectables, pills, emergency contraception, male condom, female condom, or cycle beads), 50.3% were male and 49.7% were female. The majority of current modern method users were over 21 years (57.0%) and had attended secondary school (49.2%) [Table 11].

Table 11. Current users of modern contraception by background characteristics

	Overall (N=593)		Males (N=335)		Females (N=258)	
	W%	N	W%	N	W%	N
Sex						
Male	50.3%	335	--	--	--	--
Female	49.7%	258				
Age						
15-17 years	6.8%	50	6.6%	37	7.0%	13
18-20 years	36.2%	271	33.9%	156	38.6%	115
21-24 years	57.0%	272	59.5%	142	54.4%	130
Highest level of education						
Never	0.0%	4	0.0%	2	0.0%	2
Primary	21.2%	45	20.5%	16	22.0%	29
Post-primary	0.6%	3	0.2%	1	1.1%	2
Secondary	49.2%	326	44.3%	176	54.1%	150
College	18.4%	149	25.6%	94	11.2%	55
University	10.5%	66	9.4%	46	11.6%	20

Contraceptive Procurement

For questions related to contraceptive procurement, participants were only asked about their "main" method, or the method that they use most of the time, if they selected more than one current method. The highest percentage of participants obtain their current, primary method of contraception at a pharmacy (29.9%) or a health center (29.5%) [Table 12].

Table 12. Source of current main method among current users

	Overall		Males		Females	
	W%	N	W%	N	W%	N
Source of current main method	**(N=564)***		**(N=318)**		**(N=246)**	
University hospital	0.8%	9	1.6%	9	0.0%	0
General hospital	5.5%	19	7.0%	11	4.0%	8
Health center	29.5%	148	30.0%	75	29.1%	73
Family planning clinic (like FPAK)	4.8%	24	1.4%	6	8.3%	18
Mobile clinic	0.5%	3	0.6%	2	0.3%	1
Community distributor / Fieldworker / Community health volunteer	3.9%	24	5.7%	18	2.1%	6
Private hospital / Clinic	6.3%	30	2.1%	12	10.6%	18
Pharmacy	29.9%	201	31.7%	118	28.2%	83
Private doctor or nurse	1.7%	5	0.5%	3	2.9%	2
Shop / Store / Kiosk	8.6%	43	12.5%	34	4.6%	9
Faith-based organization / Church / Mosque	0.4%	2	0.0%	0	0.8%	2
Friend / Relative / Partner	2.7%	19	3.7%	16	1.7%	3
Non-profit organization	3.5%	26	1.6%	7	5.4%	19
Market / Hawker	0.0%	0	0.0%	0	0.0%	0
Other	1.7%	10	1.7%	7	1.7%	3
Don't know / No response	0.2%	1	0.0%	0	0.3%	1

*Current contraceptive users

In Table 13, method source is displayed by type of method procured. LARCs includes implant and IUD, short-acting methods include injectables and pills, and coital-dependent methods include male condoms, female condoms, and EC. LARC users most commonly reported going to a public facility like a general hospital (13.5%) or health center (37.2%) to obtain their method, as did users of short acting methods, of whom nearly half reported obtaining their method at a health center (44.4%). For users of condoms or EC, slightly more than one-third obtain their method at a pharmacy (35.6%) and another quarter of users obtain from a health center (26.6%).

Table 13. Source of current main method among current users by type of method

	LARC users (N=59)		Short-acting method users (N=57)		Coital-dependent method users (N=445)	
	W%	N	W%	N	W%	N
Source of current main method						
University hospital	0.0%	0	0.0%	0	1.1%	9
General hospital	13.5%	5	1.3%	2	4.9%	12
Health center	37.2%	23	44.4%	23	26.6%	102
Family planning clinic (like FPAK)	9.6%	9	7.1%	2	3.8%	13
Mobile clinic	0.0%	0	1.4%	1	0.4%	2
Community distributor / Fieldworker / Community health volunteer	0.0%	0	0.0%	0	5.2%	24
Private hospital / Clinic	17.1%	7	15.2%	6	3.4%	17
Pharmacy	1.6%	2	16.4%	15	35.6%	180
Private doctor or nurse	7.6%	1	0.0%	0	1.1%	4
Shop / Store / Kiosk	0.0%	0	0.0%	0	11.4%	43
Faith-based organization / Church / Mosque	1.3%	1	2.3%	1	0.0%	0
Friend / Relative / Partner	0.0%	0	0.0%	0	3.3%	18
Non-profit organization	12.1%	11	10.3%	6	1.2%	9
Market / Hawker	0.0%	0	0.0%	0	0.0%	0
Other	0.0%	0	1.7%	1	2.0%	9
Don't know / No response	0.0%	0	0.0%	0	0.2%	1

Table 14 shows that most users reported that they obtain their current method themselves (77.0%), although this percentage was lower for females (62.6%) than for males (91.1%). Among adolescents aged 15-19 years, 46.4% of girls and 83.3% of boys obtain their current method themselves (not shown in table). More females (34.2%) rely on their partner to obtain their method than males (4.3%). Among those who reported that they rely on their partner or another person to obtain their current method, 46.4% say that they are "entirely" dependent on that person to obtain the method, 27.8% said that they are "somewhat" dependent, and 25.4% said that they are "not at all" dependent. The most common reason for relying on someone else to obtain contraception was that it is easier or more convenient (48.0%). This response was most commonly cited by both male and females (46.1% and 48.5%, respectively), although a large proportion of females also reported that obtaining the method is their partner's responsibility (39.6%). More males than females reported that the other person who obtains the method knows better where to go to obtain it (32.0% vs. 15.5%). More than one reason for relying on someone else could be selected by a participant.

Table 14. Reliance on self vs. others to obtain contraception among current users

	Overall		Males		Females	
	W%	N	W%	N	W%	N
	(N=564)*		(N=318)		(N=246)	
Person who obtains current main method						
Self	77.0%	428	91.1%	284	62.6%	144
Partner	19.1%	116	4.3%	20	34.2%	96
Other	3.9%	20	4.6%	14	3.2%	6
Level of dependence on others to obtain current method	(N=136)**		(N=34)		(N=102)	
Entirely dependent	46.4%	55	27.4%	7	51.0%	48
Somewhat dependent	27.8%	40	25.8%	11	28.3%	29
Not dependent	25.4%	40	46.8%	16	20.3%	24
No response	0.4%	1	0.0%	0	0.4%	1
Reasons for relying on someone else for obtaining method (all that apply)						
Easier/more convenient	48.0%	59	46.1%	16	48.5%	43
It is my partner's responsibility	32.3%	46	1.8%	2	39.6%	44
Allows the other person to pay	12.7%	17	1.0%	1	15.5%	16
The other person knows better where to go	18.7%	30	32.0%	13	15.5%	17
Fear that I will be denied the method	3.2%	8	6.7%	4	2.3%	4
Fear that someone will see me obtaining the method	22.3%	33	14.4%	5	24.2%	28
Fear of being shamed by provider for obtaining a method	9.3%	18	7.8%	4	9.7%	14
Other	0.9%	2	2.0%	1	0.7%	1

*Current contraceptive users

**Respondents who report that a partner or "other" person obtains their current method

Table 15 disaggregates the data presented in Table 14 by current contraceptive users whose current main method is male-controlled (male condoms) and those whose current main method is female-controlled (pills, emergency contraception, female condoms, cycle beads). IUD, implant, and injectables, while female-controlled, are excluded from this grouping because a female user cannot truly rely on someone else to obtain this method for them. The female-controlled methods classified here can be obtained by a male partner for the female partner's use, as male condoms can be obtained by a female partner for the male partner's use.

In exploring the reasons why participants rely on others to obtain their method for them by type of method, the sample size greatly diminishes (n=100 for users of male-controlled methods; n=22 for users of female-controlled methods). This should be considered when interpreting the percentages reported.

After disaggregating by these two types of users, Table 15 shows that 93.4% of males who use a male-controlled method obtain the method themselves, compared to 23.3% of females. By contrast, 72.4% of female users of a male-controlled method rely on their partner to obtain it compared to 1.9% of male users. Of the 78 females who rely on their partner or another person, 55.0% reported that they are "entirely" dependent and 28.7% are "somewhat" dependent on the other person to obtain it. Only 22 males reported that their partner or another person obtains their method. Among females who are "entirely" or "somewhat" dependent, the most common reasons for relying on someone else were that it was easier/more convenient and they consider it the partner's responsibility to obtain the method.

Among users of female-controlled methods, 74.8% of females obtain their method themselves compared to 51.3% of males. Males were more likely to report that their partner obtains the method (49.8%).

Table 15. Current users' reliance on others to obtain current method by method type

	Users of male-controlled method[1]						Users of female-controlled methods[2]					
	Overall		Males		Females		Overall		Males		Females	
	W%	N	W%	N	W%	N	W%	N	W%	N	W%	N
Person who obtains current method	**(N=395)***		**(N=298)**		**(N=97)**		**(N=64)**		**(N=11)**		**(N=53)**	
Self	73.3%	294	93.4%	276	23.3%	18	72.5%	42	51.3%	6	74.8%	36
Partner	22.1%	86	1.9%	8	72.4%	78	25.9%	21	48.7%	5	23.5%	16
Other	4.6%	15	4.8%	14	4.2%	1	1.5%	1	0.0%	0	1.7%	1
Level of dependence on others to obtain current method	**(N=100)****		**(N=22)**		**(N=78)**		**(N=22)**		**(N=5)**		**(N=17)**	
Entirely dependent	51.2%	43	33.4%	4	55.0%	39	38.7%	8	15.9%	2	43.4%	6
Somewhat dependent	28.5%	33	27.3%	10	28.7%	23	25.9%	5	0.0%	0	31.4%	5
Not dependent	19.9%	24	39.2%	8	15.7%	16	35.4%	9	84.1%	3	25.2%	6
No response	0.5%	1	0.0%	0	0.6%	1	0.0%	0	0.0%	0	0.0%	0
Reasons for relying on someone else for obtaining method (all that apply)												
Easier/more convenient	50.1%	45	44.3%	11	51.3%	34	--	--	--	--	--	--

It is my partner's responsibility	33.4%	35	0.0%	0	40.6%	35	--	--	--	--	--	--
Allows the other person to pay	12.9%	12	1.4%	1	15.3%	11	--	--	--	--	--	--
The other person knows better where to go	15.5%	21	30.3%	8	12.3%	13	--	--	--	--	--	--
Fear that I will be denied the method	3.4%	6	7.0%	3	2.6%	3	--	--	--	--	--	--
Fear that someone will see me obtaining the method	22.7%	26	18.0%	4	23.7%	22	--	--	--	--	--	--
Fear of being shamed by provider for obtaining a method	10.0%	13	5.5%	2	11.0%	11	--	--	--	--	--	--
Other	0.7%	1	0.0%	0	0.8%	1	--	--	--	--	--	--

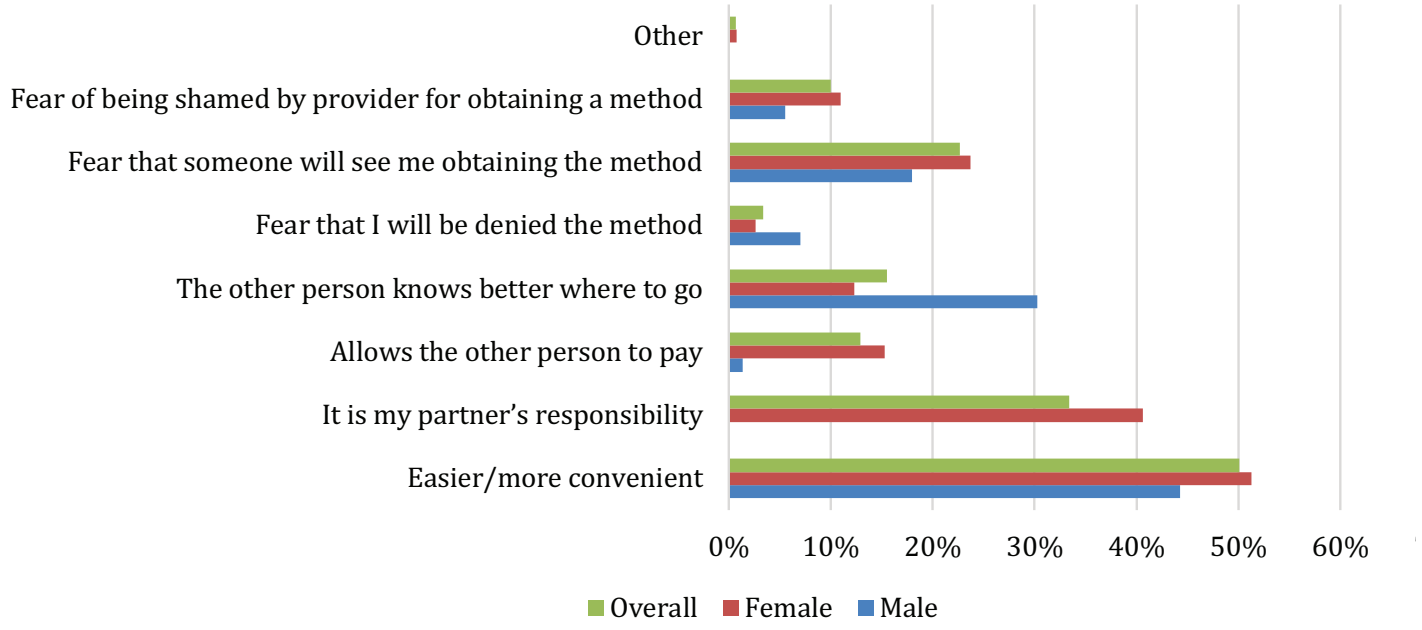
[1]Male condom [2]Pill, emergency contraception, female condom, cycle beads

*Current contraceptive users **Respondents who report that a partner or "other" person obtains their current method

Figure 5 illustrates the reasons why participants rely on a partner or other person to obtain their current method for users of male-controlled methods (male condoms) by sex. Participants could select all responses that apply.

Figure 5. Reasons for relying on others for method procurement among male and female users of male-controlled methods*

*Male-controlled methods include male condoms



Relationship Power Dynamics and Threats to Sexual/Reproductive Autonomy

Another theme explored in the questionnaire was power dynamics in relationships and threats to the respondent's sexual or reproductive autonomy. Among sexually active respondents who reported that they have a current/recent partner, 61.0% reported that they felt " very capable" of negotiating sex with their partner, although this differed by sex [Table 16]. Female respondents were more likely than male respondents to report feeling "very capable" negotiating sex (68.6% vs. 49.4%, respectively). Slightly more respondents (63.5%) felt "very confident" using contraception with their partner: 65.4% of males and 62.3% of females. About two-thirds of respondents reported that they discussed using contraception with their current/recent partner before having sex with him or her for the first time.

Among all respondents who reported having a current/recent partner, 90.4% felt that their partner shows that they care even when they disagree. About half of respondents reported that they try not to cause problems because they are afraid of what their partner might do and about 20% reported that their partner has ever been violent towards them. Among female respondents, 85.7% reported that they have received something from their current/recent partner, and 85.0% of male respondents reported providing something to their current/recent partner. Options for something received or provided to their partner sex included money, food, gifts, safety, shelter, transportation, or other; more than one option could be selected for both questions.

In terms of reproductive coercion, 18.1% female respondents reported that any partner, past or current, had ever pressured them not to use birth control and 17.5% reported that a partner had agreed to use a condom and then removed it during sex at any point in their sexual history, also known as "stealthing". A higher percentage of male respondents (34.8%) reported that they had agreed to use a condom and then removed it during sex with any partner in the past. Both male and female respondents reported ever receiving something in exchange for sex outside of their current relationship (22.6% and 19.4%, respectively). More young men reported ever providing something in exchange for sex (29.8%) than young women (11.0%). Options for things exchanged for sex were the same as those listed above and multiple options could be selected.

Table 16. Relationship power dynamics and threats to sexual/reproductive autonomy among sexually active respondents with a partner, all respondents with a partner, and all sexually active respondents

	Overall		Males		Females	
	W%	N	W%	N	W%	N
Capability of negotiating sex with partner	**(N=838)***		**(N=391)**		**(N=447)**	
Very capable	61.0%	469	49.4%	172	68.6%	297
Capable	26.6%	244	32.7%	133	22.6%	111
Somewhat capable	5.6%	67	9.3%	48	3.2%	19
Not at all capable	6.3%	54	7.6%	35	5.6%	19
Don't know / No response	0.4%	4	1.0%	3	0.0%	1
Confident using contraception with partner						
Very confident	63.5%	532	65.4%	250	62.3%	282
Confident	26.2%	215	29.0%	106	24.5%	109
Somewhat confident	3.3%	37	2.9%	20	3.6%	17
Not at all confident	6.4%	49	2.7%	14	8.8%	35
Don't know / No response	0.5%	5	0.0%	1	0.9%	4
Discussed contraception with partner before first intercourse with him/her	68.0%	575	68.0%	256	67.9%	319

	(N=1123)**		(N=571)		(N=552)	
My partner shows respect for my feelings about issues we disagree on	90.4%	1038	91.3%	534	89.7%	504
I try not to cause any problems with my partner because I am afraid of what my partner might do	52.3%	588	59.4%	345	47.0%	243
Partner has ever been violent	18.7%	200	20.7%	111	17.2%	89
Respondent receives something from partner in current/recent relationship (Females only)	NA	NA	NA	NA	85.7%^	478^
Respondent provides something to partner in current/recent relationship (Males only)	NA	NA	85.0%^	473^	NA	NA
	(N=965)* **		**(N=478)**		**(N=487)**	
Has a partner ever pressured you not to use birth control, taken your birth control (like pills) away from you, or kept you from going to the clinic to get birth control?	NA	NA	NA	NA	18.1%	82
Has a partner ever agreed to use a condom and then removed it during sex?	NA	NA	NA	NA	17.5%	92
Have you ever agreed to use a condom then removed it during sex?	NA	NA	34.8%	163	NA	NA
Receipt of something in exchange for sex outside of current/recent relationship	20.7%	217	22.6%	114	19.4%	103
Provision of something in exchange for sex outside of current/recent relationship	18.8%	194	29.8%	145	11.0%	49

*Respondents who have had sex with current/recent partner

**Respondents with a current/recent partner

***Sexually active respondents

^Corrected in Version 2 (25 September 2020)

Attitudes and Norms about Contraception

In order to collect information on different norms related to contraception and family planning, the survey presented a series of statements that all respondents were asked to rate from "strongly agree" to "strongly disagree". About half of males and about 45% of females either "strongly" agreed or "mostly" agreed that male condom's reduce men's sexual pleasure. Approximately 60% of males and females reported that they "strongly" or "mostly" agreed that pregnancy and a baby can bring positive attention to young women. A lower percentage, about 27% of females and 37.8% of males, "strongly" or "mostly" agreed that women who contraception are promiscuous [Table 17].

Table 17. Contraception-related attitudes and norms among all respondents

	Overall (N=1354)		Males (N=690)		Females (N=664)	
	W%	N	W%	N	W%	N
Male condoms reduce men's sexual pleasure						
Strongly agree	24.8%	319	30.2%	171	20.9%	148
Mostly agree	17.1%	257	20.1%	150	14.9%	107
Neither agree nor disagree	20.6%	295	20.5%	163	20.6%	132
Mostly disagree	14.7%	196	12.2%	91	16.6%	105
Strongly disagree	18.3%	241	13.2%	95	21.8%	146
No response	4.6%	46	3.8%	20	5.2%	26
Pregnancy and a baby can bring positive attention to young women						
Strongly agree	36.2%	467	37.7%	211	35.2%	256
Mostly agree	23.1%	310	23.3%	178	23.1%	132
Neither agree nor disagree	9.2%	164	10.7%	105	8.1%	59
Mostly disagree	12.7%	160	10.8%	72	14.1%	88
Strongly disagree	16.4%	225	15.0%	108	17.3%	117
No response	2.3%	28	2.5%	16	2.2%	12
Women who use contraception are promiscuous						
Strongly agree	16.1%	185	18.7%	98	14.2%	87
Mostly agree	15.5%	216	19.1%	127	12.9%	89
Neither agree nor disagree	18.8%	301	21.7%	190	16.7%	111
Mostly disagree	15.2%	223	11.2%	103	18.1%	120
Strongly disagree	29.9%	380	23.5%	140	34.4%	240
No response	4.5%	49	5.8%	32	3.6%	17

Contraceptive Demand, Community Attitudes, and Exposure to Messaging

Participants reported a high level of exposure to contraceptive messages in the media (97.3%) but were less likely to report having attended a community event where contraception was favorably discussed (41.2%) or favorable community attitudes towards their use of a contraceptive method in general (50.3%). In the last 12 months, 50.4% of respondents reported that a friend or relative recommended that they use a contraceptive method. Over two-thirds of respondents (68.2%) had heard government officials speaking favorably about contraception in public, compared to 7.6% who had heard this leadership category speaking negatively about contraception. [Table 18].

Table 18. Contraceptive demand, community attitudes and exposure to messaging among all respondents

	Overall (N=1354)		Males (N=690)		Females (N=664)	
PARTICIPANT RESPONDED "YES" TO THE FOLLOWING:	W%	N	W%	N	W%	N
In the last 12 months, has a friend and/ or relative recommended that you use a contraceptive method?	50.4%	722	56.1%	387	46.3%	335
Have you attended a community event in the last year where contraception was favorably discussed?	41.2%	582	39.0%	269	42.7%	313
Do you think there are some people in your community who will call you bad names or avoid your company if they knew that you were using a contraceptive method?	38.5%	492	32.6%	194	42.7%	298
Do you think there are some people in your community who will praise, encourage, or talk favorably about you if they knew that you were using a contraceptive method?	50.3%	701	57.8%	383	45.0%	318
In the past 12 months, have you heard any of the following people speaking publicly in FAVOR of contraceptive?						
Government official (national level)	68.2%	423	68.5%	231	68.0%	192
County or municipal leaders	0.0%	0	0.0%	0	0.0%	0
Civic / Community leaders	31.5%	466	28.3%	237	33.9%	229
Religious leader	23.9%	345	28.4%	206	20.7%	139
In the past 12 months, have you heard any of the following people speaking publicly AGAINST contraceptive?						
Government official (national level)	7.6%	127	9.6%	72	6.2%	55
County or municipal leaders	0.0%	0	0.0%	0	0.0%	0
Civic / Community leaders	9.5%	154	8.6%	81	10.1%	73
Religious leader	32.7%	507	31.9%	245	33.3%	262
Reported exposure to contraceptive messages on the radio, television, print, by text, or on social networks in the last few months	97.3%	1333	97.0%	678	97.5%	655

Quality of Contraceptive Services

Among current users who reported that they obtain their current method of contraception themselves, 99.0% obtained their method of choice at the visit. Young women were more likely to report than young men that they were informed about other methods, beyond the method they obtained, at their visit (70.4% vs. 46.7%, respectively) [Table 19]. Another indicator of quality care is being provided with full information about the method, including possible side effects and slightly less than half of users who obtained the method themselves were told about side effects associated with the method they obtained. This figure was almost double among females (67.0%) compared to males (34.4%). Of those respondents, 79.5% were told what they should do if they or their partner experienced side effects or problems.

Table 19. Quality of contraceptive services reported by current users

	Overall		Males		Females	
	W%	N	W%	N	W%	N
	(N=428)*		(N=284)		(N=144)	
Respondent obtained method s/he wanted at visit	99.0%	421	99.0%	280	99.1%	141
Provider told respondent about other contraceptive methods other than current main method at visit	56.3%	228	46.7%	124	70.4%	104
Provider told respondent about method side effects at visit	47.5%	189	34.4%	90	67.0%	99
	(N=189)**		(N=90)		(N=99)	
Provider told respondent what to do if s/he experienced side effects	79.5%	145	72.5%	63	84.8%	82

*Current users who reported that they obtain their contraceptive method themselves

**Current users who were told about side effects at visit

Summary of Results

Following the pilot YRDSS implementation in Abidjan, this methodology was chosen to be replicated in Nairobi for a similar study of contraceptive knowledge, behaviors, and practices of unmarried youth as a way of uncovering data on hidden behaviors and practices. Modern contraceptive prevalence use was estimated at 53% for males and 37% for females in this study; which is higher than recent PMA2020 estimates for unmarried females 15-24 years in Nairobi (17.4%). Use of highly effective, non-coital-dependent methods was more commonly reported among young women (implant 20%; injectables 16%) relative to young men (<2%).

The majority (91%) of young men in the study procured their own contraceptive methods; however, approximately one-third of young women relied on their partners for family planning. Among the young women who rely on their partner or another person to obtain their method, over half indicated they were entirely dependent on this person for their method. Convenience and partner responsibility factored heavily into dependence on partners for contraception, though approximately one in four (24%) indicated they felt fear for being shamed by a provider for obtaining a family planning method. These patterns speak to gendered social expectations for family planning and sexual activity that interfere with young women successfully procuring their own contraceptive methods.

The heavy reliance on condoms for family planning, particularly among male youth (95%) is striking in this setting of high HIV prevalence. Results may reflect a relatively low level of knowledge on method efficacy; less than one-third of male participants correctly indicated that coil/IUDs are more effective in pregnancy prevention than condoms. High levels of HIV-related concern (>80%) may also drive condom use for this population of young unmarried youth. Current evidence of partner concurrency (20% among males), and condom removal or “stealthing” (34.8% lifetime prevalence among males) suggest significant risk for HIV and other sexually transmitted infection within this high HIV prevalence setting. Results illustrate unmet needs for integrated family planning and HIV risk reduction.

While method recognition was nearly ubiquitous at >98% for both young men and women, less than half of surveyed youth were able to correctly differentiate the efficacy of common methods including oral contraceptives, coil/IUD, and condoms. These data speak to unmet needs for communicating information about the most efficacious methods. Where women’s access to contraception is challenged due to fear of being shamed by partners, accessing them with information on method efficacy becomes more difficult, and may require increasingly innovative communication strategies.

Adolescent and young adult women in this study reported a range of potential power imbalances within their current partnerships, including pressure and interference in family planning (18%), partner violence (17%), fear of causing trouble (47%), and monetary (63%) and other transactions within relationships (86% overall); these factors can interfere with successful contraceptive use and enable early and unintended pregnancy. Addressing relationship dynamics and agency within relationships is essential to ensuring knowledge, access, and use of modern contraceptive methods, and ensuring women’s empowerment and wellbeing as they begin to form partnerships for the first time.

Recommendations

1. Address stigma and provider bias for young women seeking SRH services

Many young women in the study report that they rely on their partner (34.2%) or another person (3.2%) to obtain their main method of contraception, and reliance on a partner increases significantly when looking at young women who report male condoms as their main method (72.4%). One key reason for relying on another person is fear of being seen obtaining the method, reported by 24.2% of this group.

To improve uptake of contraception and reduce early pregnancy, it is critical to address social barriers to obtaining contraception, like social stigma for unmarried young women seeking family planning and potential provider bias when treating this population. These barriers may be deterring young women from obtaining methods themselves and leading them to rely on partners to procure coital-dependent methods, which limits their choice and autonomy in contraceptive decision-making. Implementation of community outreach and behavior change strategies can help influence positive norms around contraceptive use for young people and provider trainings on youth-friendly services can comprehensive SRH care can mitigate potential bias in healthcare settings.

2. Develop and strengthen tailored AYSRH messaging from information sources preferred by youth

a. From health centers and healthcare professionals

This study showed that both young men and women consider doctors/nurses and health centers as two of their top three preferred sources for contraception information. Nearly one-quarter of young women (24.7%) and 17.4% of young men would prefer to receive information about contraception from healthcare providers like doctors or nurses. Healthcare providers themselves and information dispensed from healthcare centers appear to be trusted information sources for this age group, who reported healthcare centers as one of their main places to obtain contraception, as well. As other research has shown provider bias towards adolescents and youth seeking family planning services, messaging and counseling from healthcare professionals should take care to be both balanced and comprehensive for the many youth that seek their guidance.

b. From parents

For the largest proportion young women in this study, their preferred source of information on contraception is their mother (27.5%). While there is often a perception that the generation gap between parents and children limits discussion of contraception, and that young people prefer to get information from peers, current results show that over one in four young women prefer to receive contraception information from their mothers. These data clearly demonstrate that AYSRH interventions must engage mothers as valuable sources of information for youth, particularly young women. Mothers who may not be comfortable as the direct information source for their children should receive supportive information to refer their daughters and sons to trusted information sources within the health system. Mothers who may be engaged in family planning demand generation activities for their own methods may also serve an additional role in connecting their adolescent and young adult children with care.

3. Consistent condom use: improve messaging and acknowledge gaps

Male condoms were the most commonly reported method used by current contraceptive users by a wide margin, particularly among young men: over 90% of male users and 36.1% of female users reported this as their main method. However, 17.5% of sexually active young women reported that a partner had ever agreed to use a condom and then removed it during sex. About one-third of sexually active young men reported ever having done this themselves during a sexual encounter. Providers and youth serving organizations should be aware of the possibility of coercion as related to condom removal. Protection against pregnancy, STIs, and HIV is compromised if condoms are not correctly and consistently used during each sexual encounter. Since this is a method that can often be obtained without directly interacting with a healthcare provider, mass communication strategies aimed at youth should work to fill this counseling and information gap about correct and consistent condom use, especially at the start of adolescents' sexual activity.

4. Develop communication strategies to share information on method mix and method effectiveness for adolescents and youth

Communication strategies at both the level of mass media and within healthcare facilities should share information on method mix, including more highly effective methods. In the survey questions comparing effectiveness of two contraceptive methods, less than half of respondents selected the correct method in any of these questions (Table 8). One reason given by 80% of male condom users for using male condoms with their current or most recent partner is that they "think it an effective method for pregnancy prevention." The responses in Table 8 comparing method effectiveness also support this idea that respondents believe male condoms are a highly effective contraceptive method, even compared to IUDs or pills.

Many respondents, young men especially, had not heard of long-acting methods, like implants and IUDs. For example, only 20% of young men and 47% of young women had heard of IUDs, and 35% of young men and 63% of young women had heard of implants. While improved messaging around correct condom use is needed, as highlighted in Recommendation 2, companion messaging about highly effective methods and the comparative effectiveness of different methods available should target young people, as well.

5. Address relationship dynamics and agency within relationships

Several types of threats to sexual and reproductive autonomy were reported in this study by young women, including partner pressure to not use contraception, condom removal during sex, and partner violence. These factors represent important threats to empowerment and agency; moreover, they can interfere with successful contraceptive use and enable early and unintended pregnancy, particularly among young women who rely on their partner to obtain their contraceptive method. Programs to address personal agency should target young women, with the expansion of safe spaces, afterschool programs, and counseling for issues such as intimate partner violence. Healthy relationship skills-building and programming can address both young men and young women.

Transactions within relationships were very common in this sample, and were described as normative in the formative research. Specifically, 85% of young men reported providing something to their current or recent partner and 86% of young women reported receiving something from their partner. For 63% of young women in a relationship, they reported receiving money from their partner. These data suggest the importance of multi-sectoral approaches to addressing gaps in AYSRH. Specifically, sexual and reproductive health programs can partner with income generation programs and other programs that improve gender equity in relationships as well as access to financial resources and meaningful employment.

6. Harness the supportive community norms around contraception

About 50% of the study respondents reported favorable community attitudes towards contraception, as well as low levels of negative public discourse about contraception from any leadership group. Positive community attitudes and supportive public statements from leaders can be built upon to generate community support and ownership of programs aimed at addressing adolescent and youth SRH, including teenage pregnancy reduction and comprehensive sexuality education.

While support for contraception at the community level appears high, the findings of this study also show that the largest share of both female and male respondents believe that pregnancy and a baby can bring positive attention to young women (36.2% overall). Behavior change strategies at the community level should not only highlight the positive impact of contraception in general and for youth specifically, but the ways pregnancy affect the lives of young people. While young men may not feel as implicated if their partner becomes pregnant, pregnancy can negatively impact educational and employment outcomes for young women.

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Appendix 1: The Challenge Initiative (TCI) Indicators Compiled

Indicator	Overall		Males		Females	
	N	W%	N	W%	N	W%
	(N=1354)		(N=690)		(N=664)	
	N = All participants					
Contraceptive use and knowledge						
Current user (modern method)	43.6%	593	52.7%	335	37.2%	258
Among respondents aged 15-19 years (n=640)	28.3%	203	36.6%	130	23.2%	73
Among respondents aged 20-24 years (n=714)	54.6%	390	62.5%	205	48.3%	185
Current user (LARC method)	5.9%	72	1.3%	14	9.1%	58
Among respondents aged 15-19 years (n=640)	2.9%	17	0.7%	6	4.2%	11
Among respondents aged 20-24 years (n=714)	8.0%	55	1.6%	8	13.1%	47
Knows a place to obtain contraception	84.1%	1163	83.1%	574	84.8%	589
Among respondents aged 15-19 years (n=640)	75.5%	522	78.1%	292	73.9%	230
Among respondents aged 20-24 years (n=714)	90.3%	641	86.1%	282	93.6%	359
Social influence on contraceptive use						
Do you think there are some people in your community who will praise, encourage, or talk favorably about you if they knew that you were using a contraceptive method? **TCI indicator:** Respondents who report favorable community attitudes toward contraception	50.3%	701	57.8%	383	45.0%	318
Report exposure to contraceptive messages on the radio, television, print, by text, or on social networks in the last few months	97.3%	1333	97.0%	678	97.5%	655
Among respondents aged 15-19 years (n=640)	94.6%	628	94.6%	362	94.6%	266
Among respondents aged 20-24 years (n=714)	99.2%	705	98.6%	316	99.7%	389
Recommended any FP method to a friend/family member in last 12 months	40.7%	618	45.0%	322	37.7%	296
Among respondents aged 15-19 years (n=640)	25.8%	219	34.2%	135	20.7%	84

Among respondents aged 20-24 years (n=714)	51.4%	399	51.6%	187	51.2%	212
Attitudes and norms about contraception						
Male condoms reduce men's sexual pleasure						
Strongly agree	24.8%	319	30.2%	171	20.9%	148
Mostly agree	17.1%	257	20.1%	150	14.9%	107
Neither agree nor disagree	20.6%	295	20.5%	163	20.6%	132
Mostly disagree	14.7%	196	12.2%	91	16.6%	105
Strongly disagree	18.3%	241	13.2%	95	21.8%	146
No response	4.6%	46	3.8%	20	5.2%	26
Pregnancy and a baby can bring positive attention to young women						
Strongly agree	36.2%	467	37.7%	211	35.2%	256
Mostly agree	23.1%	310	23.3%	178	23.1%	132
Neither agree nor disagree	9.2%	164	10.7%	105	8.1%	59
Mostly disagree	12.7%	160	10.8%	72	14.1%	88
Strongly disagree	16.4%	225	15.0%	108	17.3%	117
No response	2.3%	28	2.5%	16	2.2%	12
Women who use contraception are promiscuous						
Strongly agree	16.1%	185	18.7%	98	14.2%	87
Mostly agree	15.5%	216	19.1%	127	12.9%	89
Neither agree nor disagree	18.8%	301	21.7%	190	16.7%	111
Mostly disagree	15.2%	223	11.2%	103	18.1%	120
Strongly disagree	29.9%	380	23.5%	140	34.4%	240
No response	4.5%	49	5.8%	32	3.6%	17
	(N=128)		**(N=54)**		**(N=74)**	
	N = Non-users who have had sex in the last 3 months					
"Do you think you will use a contraceptive method to delay or avoid getting pregnant at any time in the future?"	85.2%	109	87.3%	48	84.3%	61
	(N=319)		**(N=118)**		**(N=201)**	
	N = Non-users who have a current/recent partner					
Discussed the decision to avoid or delay pregnancy with partner in last 3 months	34.6%	124	26.0%	40	37.5%	84
	(N=619)		**(N=345)**		**(N=274)**	
	N = Current contraceptive users					
Current method(s) (select all that apply)						
Implant	11.1%	65	1.8%	11	20.3%	54

Intrauterine device (IUD)	1.9%	7	0.6%	3	3.1%	4
Injectables	8.8%	47	1.2%	8	16.3%	39
Oral contraceptive pills	5.6%	29	3.5%	7	7.6%	22
Emergency contraception	13.7%	112	11.4%	57	16.0%	55
Male condom	69.5%	441	95.0%	321	44.5%	120
Female condom	4.9%	45	6.0%	28	3.8%	17
Cycle beads	0.03%	1	0.1%	1	0.0%	0
Standard days / Safe days / Rhythm	6.1%	47	6.8%	26	5.4%	21
LAM / Exclusive breast feeding	0.0%	0	0.0%	0	0.0%	0
Withdrawal	9.2%	74	10.9%	49	7.6%	25
Herbal pill method	1.4%	5	0.0%	0	2.8%	5
Other method	0.4%	2	0.7%	2	0.0%	0
Don't know	0.3%	1	0.5%	1	0.0%	0
No response	0.3%	2	0.1%	1	0.4%	1
	(N=823)		**(N=409)**		**(N=414)**	
	N = Ever users of contraception					
Used a contraceptive method at first sex	74.4%	636	73.9%	313	74.7%	323
Used a contraceptive method at last sex	89.3%	742	89.3%	366	89.3%	376
	(N=381)		**(N=242)**		**(N=139)**	
	N = Current modern method users who obtain their method themselves from a health facility/clinic/hospital					
Would recommend relative/friend to provider/facility where they obtained method	92.3%	342	90.3%	210	95.0%	132
	(N=428)		**(N=284)**		**(N=144)**	
	N = Current users who reported that they obtain their contraceptive method themselves					
Current users reporting they obtained desired method at visit	99.0%	421	99.0%	280	99.1%	141
Current users reporting they were informed about side effects	47.5%	189	34.4%	90	67.0%	99
	(N=189)		**(N=90)**		**(N=99)**	
	N = Current users who were told about side effects					
Current users who were informed of what to do if they experienced side effects	79.5%	145	72.5%	63	84.8%	82
	(N=838)		**(N=391)**		**(N=447)**	

	N = Respondents who have had sex with current/recent partner					
Confident using contraception with partner						
Very confident	63.5%	532	65.4%	250	62.3%	282
Confident	26.2%	215	29.0%	106	24.5%	109
Somewhat confident	3.3%	37	2.9%	20	3.6%	17
Not at all confident	6.4%	49	2.7%	14	8.8%	35
Don't know/No response	0.5%	5	0.0%	1	0.9%	4
	(N=502)		**(N=152)**		**(N=350)**	
	N = Respondents who reported having heard of both IUD and condoms					
Provided correct response to: "Between these two choices, which is more effective in preventing pregnancy: condoms or coil/IUD?"*	42.3%	191	28.9%	43	46.3%	148
	(N=723)		**(N=298)**		**(N=425)**	
	N = Respondents who reported having heard of both pills and condoms					
Provided correct response to: "Between these two choices, which is more effective in preventing pregnancy: oral birth control pills or condoms?"*	40.0%	272	30.5%	90	44.7%	182
	(N=49)		**(N=21)**		**(N=28)**	
	N = Respondents who reported having heard of both injectables and cycle beads					
Provided correct response to: "Between these two choices, which is more effective in preventing pregnancy: injectables or standard days / cycle beads?"*	34.6%	35	32.6%	14	35.4%	21
	(N=808)		**(N=365)**		**(N=443)**	
	N = Respondents who reported having heard of emergency contraception					
Provided correct response to: "Emergency contraception (P2) is effective if taken: within 72 hours (3 days) after unprotected sex."*	89.8%	727	89.8%	324	89.8%	403