CENTRAL OPERATIONAL RESEARCH POWER TO YOU(TH) - KENYA

EXPLORING THE DYNAMICS OF SOCIAL ACCOUNTABILITY AND COMMUNITY ENGAGEMENT IN ADDRESSING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS POLICY IMPLEMENTATION GAPS IN SELECTED COUNTIES IN KENYA

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LIST OF ACRONYMS

AACSE	-	Age Appropriate Comprehensive Sexuality Education
AIDS	-	Acquired Immunodeficiency Syndrome
ADR	-	Alternative Dispute Resolution
AFIDEP	-	African Institute for Policy Development
AGYW	-	Adolescent Girls and Young Women
ASRHDIB	-	Adolescent Sexual & Reproductive Health Development Impact Bond
AU	–	African Union
AYSRHR	-	Adolescent and Youth Sexual and Reproductive Health Rights
CAAFAG	-	Children Associated with Armed Forces and Armed Groups
CBEF	-	County Budget and Economic Forums
CBOs	-	Community Based organizations
CHPs	-	Community Health Promoters
CHUs	-	Community Health Units
CMT	-	Country Management Team
COR	-	Central Operational Research
CRC	-	Convention on the Rights of the Child
CRS	-	Citizen Report Card
CSA	-	Center for Study of Adolescences
CSE	-	Comprehensive Sexuality Education
CSOs	–	Civil Society Organizations
CSOs	-	Civil Society Organisations
DS	-	Digital Storytelling
ESA	-	Eastern and Southern Africa
ESRC	-	Economic and Social Research Council
FGDs	–	Focus Group Discussion
FGM	-	Female Genital Mutilation
FGM/C	–	Female genital mutilation/cut
GBV	-	Gender Based Violence
GMT	-	Global Management Team
GTA	-	Gender Transformative Approach
HFCs	-	Health Facilities Committees
HIV	-	Human immunodeficiency virus (HIV)
HPV	–	Human Papilloma Virus
ICPD	-	International Conference on Population and Development
IPPF	-	International Planned Parenthood Federation
KDHS	-	Kenya Demographic and Health Survey
KENPHIA	-	Kenya Population Based HIV Impact Assessment
KIIs	–	Key Informant Interviews
KNBS	-	Kenya National Bureau of Statistics
LMICs	-	Low and Middle-Income Countries
MHM	-	Menstrual Hygiene Management
MIYP	-	Meaningful and Inclusive Youth Participation
MoFA	-	Ministry of Foreign Affairs (Netherlands)
NACOSTI	-	National Commission for Science, Technology and Innovation
NASCOP	-	National AIDS & STI Control Programme
NCPD	-	National Council for Population and Development
NGEC	-	National Gender and Equality Commission
NGOs	–	Non-Governmental organizations

OECD	-	Organisation for Economic Cooperation and Development
PB	–	Participatory Budgeting
PtY	-	Power to Youth
RH	-	Reproductive Health
SDG	-	Sustainable Development Goal
SEAH	-	Sexual Exploitation and Abuse
SEAH	-	Sexual Exploitation, Abuse and Harassment
SGBV	-	Sexual AND Gender Based Violence
SOA	-	Sexual Offences Act
SRH	-	Sexual and Reproductive Health
SRHR	-	Sexual and Reproductive Health and Rights
STIs	-	Sexually Transmitted Infections
TEO	-	Tunaweza Empowerment Organization
ToC	-	Theory of Change
UDHR	-	Universal Declaration of Human Rights
UNCRC	–	United National Convention on the Rights of the Child
UNCRPD	–	United National Convention on the Rights of Persons with Disabilities
UNCSW	-	United Nations Commission on the Status of Women
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund
WB	-	World Bank
WGDD	-	Women, Gender and Development Directorate
WHO	-	World Health Organization

EXECUTUVE SUMMARY

This report presents the final findings of the study "Exploring the Dynamics of Social Accountability and Community Engagement in Addressing Sexual and Reproductive Health Rights Policy Implementation Gaps in Selected Counties in Kenya." The report provides a detailed account of the methodology, management, organization, and key policy frameworks relevant to adolescent girls' and young women's sexual and reproductive health rights (SRHR). Notable visual products like figures and tables, such as the Theory of Change and statistical data on HIV prevalence and childbearing among adolescents, are also presented to support the findings.

The study was conducted at both national and county levels in Kenya, specifically focusing on four PtY program counties: Siaya, Homabay, Migori, and Kajiado. The research aimed explore the use and effectiveness of social accountability mechanisms in the context of SRHR policies and their implementation; assess the levels of community engagement, especially among adolescents and young women, in social accountability processes; and identify and document best practices and challenges in the implementation of SRHR policies and programs.

Methodology

The study adopted a participatory qualitative research design focused on process learning. The data collection methods included key informant interviews (KIIs), focus group discussions (FGDs), and in-depth interviews. The qualitative information from interviews, focus group discussions, and literature review was organized, summarized, and categorized according to objectives and themes. The data was manually and digitally analyzed using content analysis techniques and MAXQDA software. The study was coordinated by a research team including Rutgers, Amref Health Africa Kenya, PtY partners, young researchers from diverse communities, and a research consultant. The study was carried out at national level, and county teams consisting of three members each, responsible for covering each of the four counties namely, Siaya, Migori, Homabay and Kajiado.

Key findings

The key findings of the study were as follows:

SRHR Challenges: Young people, including adolescent girls and young women (AGYW), across the four counties (Siaya, Homabay, Migori, and Kajiado) demonstrated a clear understanding of sexual and reproductive health rights challenges within their communities. Common issues highlighted include limited access to SRHR services, inadequate sexual education, and societal stigma surrounding SRHR topics.
Knowledge Gaps: There was a lack of comprehensive understanding of social accountability in relation to sexual and reproductive health rights (SRHR) policy implementation and gaps. Specifically, best practices for social accountability at the community, county, and locational levels are not well-documented.
Community Dynamics and Accountability: The study highlighted complexities in community dynamics regarding the use of social accountability mechanisms. Issues of power and capacity strengthening needs among young people, particularly adolescent girls and young women (AGYW), were identified as important factors influencing their engagement and accountability actions.

Inclusive and Equitable Approaches: Effective social accountability efforts are influenced by societal values, norms, and judgments related to issues such as single motherhood, sexuality, and fertility. Inclusive, multi-actor, and rights-based approaches are essential to bridge gaps in social accountability.

Effective Tools and Strategies: Several tools such as citizen/community scorecards, petitions, social audits, public hearings, participatory planning and budgeting, and citizen charters are highlighted as pivotal for social accountability. However, there is a need for the practical application of these tools to be strengthened.

Effectiveness of Social Accountability Mechanisms: Various social accountability tools such as citizen scorecards, social audits, and public hearings were evaluated for their effectiveness. The study found that while these tools have potential, their actual implementation and impact vary significantly across different contexts. The data revealed varying levels of community engagement in social accountability processes. Barriers to effective engagement included gender, social and cultural norms and taboo.

Limited Opportunities for Engagement: Despite the presence of various social accountability frameworks and mechanisms, young people reported limited opportunities for meaningful engagement with decision-makers.

Inconsistent Participation: Participation in policy implementation and decision-making processes by young people varied significantly across counties. Support from youth alliances and nongovernmental organizations (NGOs) facilitated better participation in some cases.

Capacity Building: The respondents identified the need for capacity-building programs to empower AGYW to understand their rights, challenge harmful cultural practices such as female genital mutilation/cutting (FGM/C), and hold leaders accountable. Young people including AGYW and SHRH advocates expressed a lack of capacity to effectively and meaningfully engage leaders and policy makers on SRHR matters and to advocate for policy change and hold decision-makers accountable.

Conclusion

Young people, including adolescent girls and young women, across the four counties in Kenya have demonstrated a clear understanding of the existing sexual and reproductive health and rights (SRHR) challenges within their communities. They recognize that SRHR are critical entitlements supported by a broad range of social accountability mechanisms and tools that empower citizens. The study concludes that young people and AGYW are aware of the SRHR challenges and the importance of social accountability mechanisms in addressing these issues. Despite the understanding, there are still barriers to effective engagement and participation in policy implementation and decision-making processes. Key factors affecting young people's participation and utilization of available social accountability mechanisms and tools included limited scope and focus of many existing SRH programs and negative gender, social and cultural norms leading to their perceived exclusion from governance and decision making spaces. Inclusive, multi-actor, and rights-based approaches are crucial to overcoming these gaps in social accountability, ensuring that community voices are heard and acted upon. The research indicates that knowledge and insights were gained which will be vital for future applications and interventions aimed at addressing SRHR challenges through social accountability. This conclusion underscores the need for continued focus on empowering young people and AGYW to meaningfully engage with, and hold duty bearers accountable for their actions and decisions.

Recommendations

Focus	Recommendations
Education and awareness	• Need for a comprehensive education and awareness program targeting AGYW and young people to facilitate their participation in decision making and social accountability processes • Promote a multi-sectoral approach to SRHR for young people and AGYW • Enhance civic education from the village level to the national level • Utilize media advocacy tools, including social media, to raise awareness and hold leaders accountable
Building capacity in social accountability and advocacy	• Establish and explore opportunities for training and capacity building of young people and AGYW for meaningful engagement social accountability and advocacy • Develop multi-level training curriculum and mentorship program for SRHR advocates and champions adaptable to AGYW platforms and spaces of engagement • Build capacity of government/decision makers including elected leaders on SRHR issues, social accountability and youth participation and engagement
Promoting AGYW participation in social accountability and decision-making processes	• Fully operationalize existing frameworks, mechanisms and youth friendly spaces for engaging young people and AGYW • Strengthen local social accountability mechanisms including the use of digital and social media spaces to raise awareness and hold leaders accountable • Establish youth-friendly participation and social accountability spaces and enhance young people and AGYW's access to decentralized participation forums and online platforms
Strengthening policy, legislative and financing environment	• Strengthen enabling policy and legislative frameworks for youth participation and engagement in decision making and social accountability at all levels • Build enabling social and cultural environment at the community level to address restrictive gender, social and cultural norms that limit AGYW and young people's participation • Strengthen social accountability mechanisms including feedback and follow-up mechanisms for young people • Advocate for increased budget allocation for public participation and social accountability activities for young people and AGYW in governance and decision making
Promoting evidence-based decision making and advocacy	• Review the existing social accountability mechanisms and approaches with primary focus on young people's and AGYW participation and engagement in decision making and social accountability processes to support evidence based SRHR advocacy • Enhance dissemination and sharing of SRHR social accountability research findings, reports and related knowledge products through TWG and grassroots CSOs networks

	• Develop and implement an innovative behavior change strategy and program to address prevailing negative gender, social and cultural norms and practices • Enhance and make the voices of the vulnerable and marginalized including young people and AGYW to ensure inclusion in governance, decision making, social accountability and advocacy processes at all levels
Further research	• Investigate best practices and case studies on effective social accountability mechanisms at community, county, and national levels to develop a comprehensive framework for the use social accountability in SRHR. • Examine the influence of cultural values, social norms, and societal judgments regarding sexuality, single motherhood, and fertility on the engagement and participation of young people, particularly girls and young women, in social accountability initiatives. • Conduct detailed assessments of the effectiveness of various tools such as citizen scorecards, social audits, and public hearings. Identify which tools are most effective in different contexts and conditions and how they can be optimized for broader application. • Explore the most effective strategies for strengthening the capacities of young people, especially AGYW, to engage in social accountability processes. This includes training, mentorship, and support systems that can empower young people and AGYW. • Investigate the mechanisms through which feedback from community-level social accountability actions is communicated back to the community and how this feedback loop can be strengthened to ensure transparency and trust in the process.

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

Sexual and reproductive health and rights are critical entitlements best supported through human rights-based approaches empowering rights-holders to claim their rights and duty bearers to fulfill their obligations.[1] Social accountability is thus increasingly proffered as a key strategy to ensuring the widest possible enjoyment of the sexual and reproductive health and rights (SRHR).[2] However, the sexual and reproductive health and rights (SRHR) of adolescents and youth is characterized by high rates of adolescent pregnancies and a high proportion of unmet family planning needs.[3] This is attributed to various factors including the social traditions, and stigma attached to SRHR decision making;[4] as well as the tension between the need for comprehensive, multi-actor and rights-based approaches that seek to "close the gaps", and a growing economic and political imperative to demonstrate efficiency, effectiveness, and returns on specific investments.[5] Studies have also shown that issues of inclusion and equity in social accountability efforts are especially affected by values, norms, and judgements related to such issues as single motherhood, sexuality, and fertility, which often influence provider and policy-maker attitudes regarding key SRHR services, as well as the quality of care provided.[6]

Thus despite, the global momentum around women's, children's, and adolescents' health, the equalizing agenda of the Sustainable Development Goals (SDGs), and the existence of laws and policies that authorize the provision of sexual and reproductive health to adolescents and young women, poor sexual and reproductive health outcomes remain a reality for many young people especially adolescent girls and young women (AGYW). It is against this backdrop that this study sought to gain a comprehensive understanding of social accountability in local contexts and to identify effective approaches and tools for promoting accountability in the implementation of Sexual and Reproductive Health and Rights (SRHR) policies in Kenya.

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[3] UNFPA (2019) Adolescent and Youth Sexual and Reproductive Health and Rights Services Key elements for implementation and scaling up services in West and Central Africa.

[4] Boydell V, Schaaf M, George A, Brinkerhoff DW, Van Belle S, Khosla R. Building a transformative agenda for accountability in SRH: lessons learned from SRH and accountability literatures. Sex Reprod Health Matters. 2019;27:64–75. doi: 10.1080/26410397.2019.1622357.

[5] Wado, Y. D., Bangha, M., Kabiru, C. W., & Feyissa, G. T. (2020). Nature of, and responses to key sexual and reproductive health challenges for adolescents in urban slums in sub-Saharan Africa: a scoping review. *Reproductive Health*, *17*(1), 1-14.

[6] Marta Schaaf, Grady Arnott, Kudzai Meda Chilufya, Renu Khanna, Ram Chandra Khanal, Tanvi Monga, Charles Otema, and Christina Wegs (2022), Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations, International Journal on Equity Health. 2022; 21(Suppl 1): 19

1.2 About Power to You(th)

The Power to You(th) Consortium was a partnership between Amref Flying Doctors, Sonke Gender Justice and Rutgers, supported by the Royal Tropical Institute and CHOICE for Youth and Sexuality as technical partners. The partnership received funding from the Dutch Ministry of Foreign Affairs (MoFA). It was the vision of the Power to You(th) Consortium, hereinafter PtY, that adolescent girls and young women (AGYW) from underserved communities would be empowered to make informed choices, enjoy their sexuality, and are free from harmful practices in gender-equitable and violence-free societies. PtY Programme's strategic objective was to contribute to more adolescent girls and young women from underserved communities being meaningfully included in all decision-making regarding harmful practices, SGBV and unintended pregnancies. This objective aligned with results one, two and four of MoFA's sexual and reproductive health and rights (SRHR) policy. This objective also aligned with specific elements of SDG 3 (adolescent fertility) and SDG 5 on sexual gender based violence (SGBV), child marriage, FGM/C).

The PtY programme was implemented in seven countries: Ethiopia, Ghana, Indonesia, Kenya, Malawi, Senegal and Uganda, from 2021 to 2025. The programme's Theory of Change (ToC); see annex 1) presents the pathways to the envisioned change and the strategies PtY applies to achieve it. Firstly, by the end of the programme, PtY wanted young people to have more knowledge on harmful practices, sexual and gender-based violence and unintended pregnancies, as well as increased agency to collectively speak up for their rights as they examine and question social norms, policies, and systems (pathway 1). PtY also wanted CSOs to take collective action and apply innovative and inclusive lobby and advocacy methods on the key issues (pathway 2). Moreover, the programme wanted societal actors to have increased knowledge and skills to act on these key issues, and to have increasingly positive attitudes towards the rights of young people as well as the need to address these key issues (pathway 3).

Lastly, PtY envisioned that by the end of the programme, state actors will have increased knowledge and skills to design and implement effective policies and laws to act on the key issues as well as recognize the rights of young people and importance of eradicating harmful practices, SGBV and unintended practices. (pathway 4). This was to be achieved by strengthening youth to claim civic space; strengthening civil society; changing harmful social norms; and policies and policy implementation.

1.3 Overview of the Central Operational Research (COR)

The PtY Kenya consortium aimed to connect the learning cycle and the programme cycle as closely as possible. Baseline studies and annual reflections were used to identify knowledge gaps or needs which were taken forward in the learning cycle for the full partnership through Central Operational Research (COR). To this end, the COR was expected to contribute to a cycle of cumulative learning which would, in turn, strengthen civil society on themes of harmful practices, sexual and gender-based violence, gender transformative approaches, meaningful and inclusive youth participation and sexual and reproductive health and rights. The approach to learning and research was collaborative and inclusive with the aim of making the best use of the tacit knowledge of all partners, involving young people in a meaningful and inclusive way, and drawing in external expertise from local and international academic partners where this could add value. Co-creation was used as a fundamental tool in the COR and wider programme to guide partnerships, including youth-adult dynamics and north-south consortium

dynamics. For the COR, this meant making the knowledge and experiences of all relevant stakeholders in the programme accessible to everyone and fostering shared ownership of the entire research process.

1.4 Problem Statement

Policies are vital to ensure that AGYW from underserved communities can enjoy their SRHR and hence can make informed choices, enjoy their sexuality, and are free from harmful practices in gender-equitable and violence-free societies. While in some countries SHRH policies are insufficiently in place, despite regional or global commitments of governments, in other cases policies banning harmful practices and criminalizing SGBV do exist, yet, their implementation lags behind. Also the synthesis report that was developed in Phase I of the COR emphasized the fact that policy implementation and lack of political will to effectively address these gaps remained a core challenge affecting young people fulfilling their SRHR. In this regard, PtY put a strong emphasis on strengthening the capacity of communities to hold to account (local) governments and institutions responsible for respecting, protecting and fulfilling their rights, through the implementation of and budgeting for relevant laws and policies (social accountability).

While more is known about, or currently mapped, when it comes to policy implementation gaps, less is known about social accountability in relation to SRHR implementation and policy gaps (PtY Report, 2022). Knowledge gaps exist among other things around best practices of social accountability, particularly at community, county and locational level; the dynamics in communities around the use of accountability mechanisms; how Power to Youth (PtY) social accountability mechanisms work, what works, what doesn't, and young people's needs and priorities when it comes to advocating for policy change and holding decision-makers accountable for policy implementation (Synthesis Report). Against this background, the study sought to gain a better and deeper understanding of social accountability in different PtY country contexts, in particular to learn how the capacity of communities could be effectively strengthened to hold their governments accountable. The study further delved into the analysis of SRHR implementation gaps at the community level.

1.5 Research Questions

1. What are effective approaches and tools to enable social accountability related to SRHR policies and implementation?
2. What are factors that contribute to community members (not) taking action to hold duty bearers accountable on SRHR?
3. What are young people's priorities and capacity strengthening needs when it comes to advocating for policy change and holding decision-makers accountable for policy implementation?

1.6 Objectives

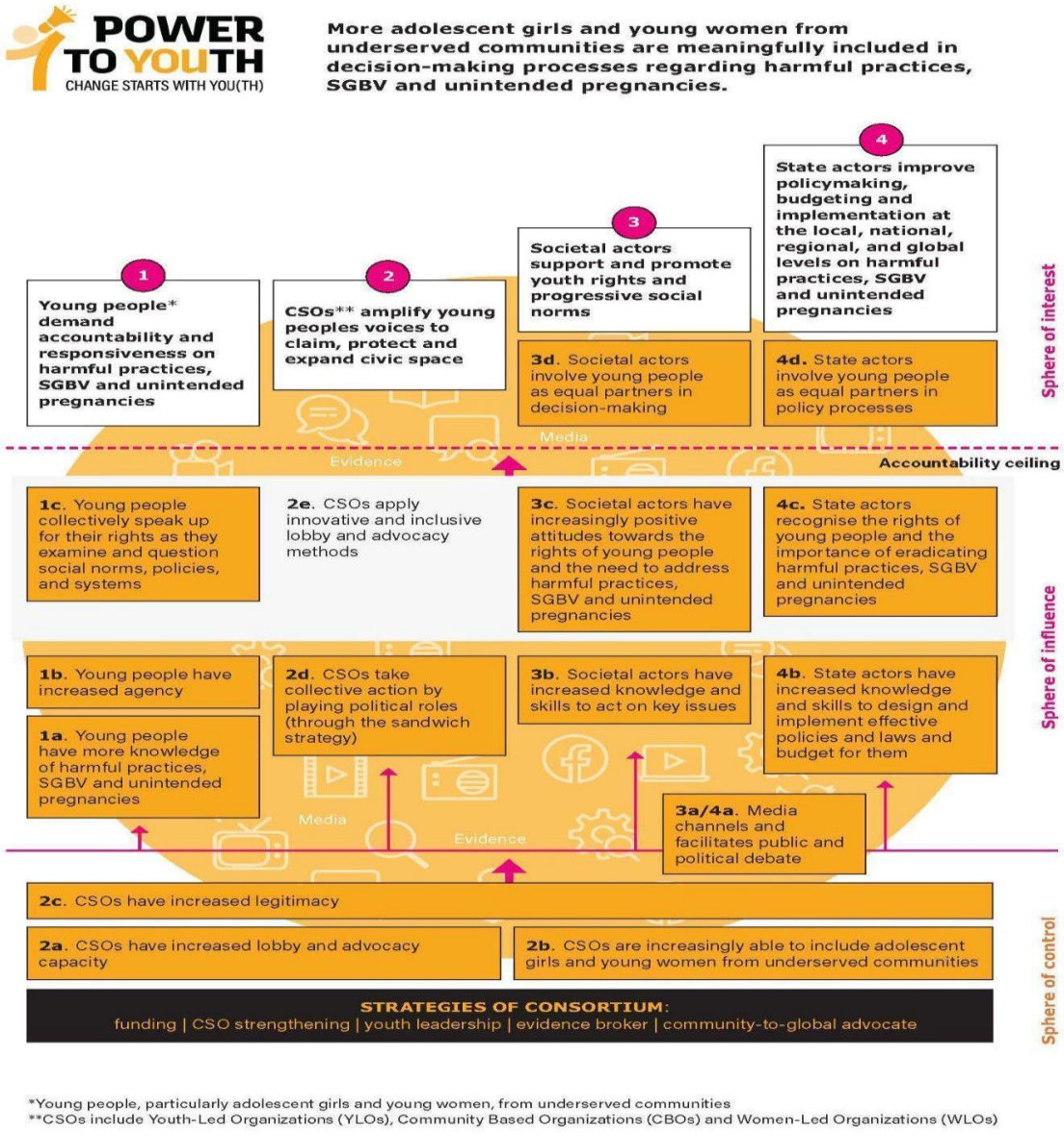
The overall objective of this research was to gain a comprehensive understanding of social accountability in local contexts and to identify effective approaches and tools for promoting accountability in the implementation of Sexual and Reproductive Health and Rights (SRHR) policies. Specifically, the study sought:

1. To identify approaches and tools for social accountability related to SRHR policies and implementation.
2. To establish factors that contribute to community members either taking or not taking action to hold duty bearers accountable for the implementation of SRHR policies.
3. To explore the priorities and capacity strengthening needs of young people in advocating for policy change and effectively holding decision-makers accountable for the implementation of SRHR policies.

1.7 Theoretical Framework

This study was based on a social science perspective. The approaches and methods used in the COR built largely on the theories underlying the programme's Theory of Change (ToC) as shown in Figure 1 below.

Figure 1: PtY Programme Theory of Change



*Young people, particularly adolescent girls and young women, from underserved communities
**CSOs include Youth-Led Organizations (YLOs), Community Based Organizations (CBOs) and Women-Led Organizations (WLOs)

The programme's ToC was underpinned by the following (overlapping) approaches and theories:

- **A Gender Transformative Approach (GTA):** This approach examines, questions and transforms harmful gender norms and power dynamics that serve to reinforce gender inequalities (and privileges).

- **A human rights-based approach:** PtY applies a human-rights based approach in the implementation of all aspects of the programme, by paying attention to Human Rights Principles and by regarding beneficiaries as active participants and placing them at the center of development initiatives as rights holders. With Meaningful and Inclusive Youth Participation (MIYP) as a core programme principle, PtY promotes young people's right to participation and places young people at the center of all program initiatives.

- **Intersectionality theory:** This theory promotes an understanding that key issues, such as harmful practices, SGBV and unintended pregnancies, are experienced in and result from a combination with other forms of structural inequality and discrimination.

- **The socio-ecological model:** The ToC is framed within a broader socio-ecological model which recognizes that gender inequality has no one cause and is perpetuated through multiple levels in society and the interplay of individual, relational, institutional, and structural level factors.

- **Social Norms Theory:** This theory looks at implicit and explicit rules regarding the appropriateness of behavior in any given situation. Social norms are defined as those implicit and explicit rules regarding the appropriateness of behavior in any given situation. Linking with the socio-ecological model, social norms are influenced by multiple factors at individual, community and societal level.

- **A feminist approach:** By taking a feminist approach, PtY seeks to redress persistent and historical power imbalances which prioritize the needs, voices and opportunities of men and boys.

In particular, the socio-ecological model, intersectionality theory and feminist theory provided a useful theoretical framework for the study. Following the socio-ecological model, the research looked at social accountability by recognizing the complex interplay between individual, relationship, community, and societal factors that influence behavior.

At the societal level, the ability of people to demand accountability is influenced by macro-level politics and ruling ideologies, while at the individual level, awareness of rights and entitlements and the capacity to voice them influences one's ability to demand accountability (Victoria B. et al 2019). Also internalized social norms may challenge one's ability to demand accountability. Dominant ideologies and related social norms may result in women, or others in underprivileged positions, not seeing themselves as "worthy of having rights", and hence not feeling empowered to exercise the right to register a complaint and demand redress (Victoria B. et al, 2019). At community level, internal hierarchies and power imbalances may

end in certain voices within the community overpowering others, which on its turn may challenge individuals and communities to hold duty bearers accountable.

Feminist and intersectionality theory were both helpful to assess the power imbalances and dynamics, more specifically by looking at the interactions between social categories (e.g. age, gender, sexual orientation, dis/ability, ethnicity, class) and the outcomes of these interactions in terms of power (Davis, 2008). The latter was particularly relevant to gain an in-depth understanding of the factors that influence AGYW and other communities engaged in the PtY programme in (not) taking action to hold duty bearers accountable. This theoretical framework was equally relevant to gain a better understanding of the capacity strengthening needs and priorities of diverse groups of young people, especially those in underprivileged positions.

1.8 Key concepts

1.8.1 Research question 1: What are effective approaches and tools to enable social accountability related to SRHR policies and implementation?

Effective approaches and tools: The PtY programme promotes and applies various approaches and tools to encourage and support social accountability. It includes the promotion of both offline and online accountability systems, such as the motion tracker, public expenditure trackers, community scorecards and citizen charters and citizen reports. Approaches and tools are considered *effective* if they support the target groups in holding duty bearers accountable and yield results that can be measured. Results are actions or changes that demonstrate accountability by duty bearers. Being accountable means ensuring that commitments are being met and policies are being implemented. This also includes ensuring transparency about what is being done; ensuring civic engagement at every level to provide feedback; ensuring that sufficient resources are allocated; and ensuring that the policies are reaching those they are supposed to reach.

***Social accountability*:** Social accountability refers to civil society holding duty bearers accountable to commitments or policies they have signed to, and obligated to implement. It includes citizens demanding services and actions from duty bearers and policy makers. This may take the form of an intentional partnership between civil society and duty bearers, and may also include efforts of relationship building or strengthening. It can be on community, county, district and national level. Given their central place in the programme, the research focused specifically on action taken by AGYW to hold duty bearers accountable. The respective focus of the three country programmes, and the specific target groups of the approaches and tools used in the country programmes, determined which other segments of civil society were considered in the study (e.g. religious and traditional leaders, groups of parents etc.).

***SRHR policies*:** The studies focused particularly on social accountability in relation to the set of policies targeted as explained in local advocacy strategy. This related to policies at the county and national levels. The research also looked at social accountability in relation to the domestication of regional and global commitments of governments (i.e. the transformation of such commitments to national laws and policies).

The next **follow-up questions** contributed to answering research question 1:

a) Which approaches and tools are applied in the PtY country programmes in order to enable young people and other segments of civil society to hold duty bearers accountable for:
    - The development of SRHR policies, including the domestication of relevant regional and global commitments?
    - The implementation of existing SRHR policies?
b) By whom, when and how are the respective approaches and tools being used?
c) Which actions taken by duty bearers to ensure commitments on young people's SRHR are being met and policies are being implemented have the respective approaches and tools made measurable contributions to?

1.8.2 Research question 2: What are factors that contribute to community members (not) taking action to hold duty bearers accountable on SRHR?

***Community members*:** As a working definition for this study, communities are groups of people that are being engaged in the PtY programme. This included AGYW, but also other groups of (young) people/ communities engaged in the PtY programme.

***Factors that contribute to community members (not) taking action*:** Quite a lot is known already about factors that influence the behavior of people when it comes to holding duty bearers accountable on SRHR. The baseline studies as well as the experiences of expert team members pointed out four types of factors: knowledge related factors; socio-cultural factors, the (un)availability of structures and resources; and (lack of) confidence among community members in the existing (legal) processes and the duty bearers.

Knowledge related factors include awareness about one's rights. According to the baseline report, young people are often not aware of their rights. Knowledge related factors also included knowledge of existing SRHR policies, and relevant regional and international and regional commitments of governments.

Socio-cultural factors include existing social norms, religious beliefs and stigma. The baseline study illustrated that these factors often relate to gender and age, and women and young people - AGYW in particular - are often most affected by them. Such norms and beliefs inform and confirm power dynamics in communities and hence the behavior of its members, including action to hold duty bearers accountable.

Resource related factors include the (in)availability and use of civil society structures, and the (in)availability of the necessary resources for these structures to operate adequately. This includes the opportunities that exist in a given context for community members to meet and/ or interact with duty bearers. The baseline report pointed out a number of formal structures as well as more informal structures (such as digital spaces and fora, including on social media).

Confidence of community members in state actors and (legal) processes can be low because of negative experiences with the (legal) system, for instance when state actors, such as the police do not address concerns conclusively. Confidence can also be affected negatively when legal processes are slow and costly. Low confidence can impede community members from taking action (PtY Baseline Report).

Also expert team also pointed out safety as a cross-cutting factor contributing to community members (not) taking action. This may link to resource related factors for instance, but also to having confidence in state actors and the legal system. Finally, the ability and will to take action may also be affected by other, personal circumstances. Moreover, while the COR did not focus exclusively on the previously mentioned factors, but it explored other possible factors.

Since relatively a lot is already known about factors that prevent community members from holding duty bearers to account, an important focus of this research question was on factors that *contribute* to community members taking action. The study explored inter alia how hindering and supporting factors interact with each other, especially which factors support community members to take action and overcome or deal with obstructing factors.

Action is defined as behavior of individuals or groups with the intent to hold duty bearers accountable. The study sought to collect comprehensive data about this behavior. Actions are perceived as processes rather than one-time events.

Duty bearers: mean persons and institutions that have a particular obligation or responsibility to respect, promote and realize human rights. This can be at community, county, national level.

The next **follow-up questions** contributed to answering research question 2:

a) Which actions - other than using the tools that are assessed in question 1 - are being taken by AGYW and other communities engaged in the PtY programme, to hold duty bearers accountable for SRHR?
b) Which factors contributed to the respective community members taking these actions, or using the approaches and tools mentioned in research question 1?
c) Which factors challenged the respective community members to take action?
d) Which factors supported the respective community members to deal with, or overcome these challenges?

1.8.3 Research question 3: What are young people's priorities and capacity strengthening needs when it comes to advocating for policy change and holding decision-makers accountable for policy implementation?

To study this research question, the following key concepts were distinguished and clarified:

Capacity strengthening needs: Capacity strengthening needs are defined as the gap between the competences and resources that are considered important for effective advocacy and holding decision makers accountable on the one hand, and the actual competencies and resources that the AGYW and other young advocates in PtY programme possess on the other hand. Resources also include social capital, power and status. Besides identifying these gaps, the study sought to provide an in-depth understanding of the gaps. To define the competences and resources needed for effective advocacy, the study built on available evidence. Moreover, the study also assessed what young advocates themselves as well as experienced advocates in the three participating countries considered important competences and resources for successful advocacy and holding decision makers accountable in their respective country contexts.

Priorities: priorities are defined as the ideas of AGYW and other young advocates about how the programme can best support them in addressing the identified gaps (i.e. the gaps between their existing competences and resources and those that are considered needed for effective advocacy and holding decision-makers accountable). This is not limited to their opinions about the approaches that are currently implemented in the programme, but also ideas about other innovative approaches explored by the study.

Young people: The African Youth Charter and Kenyan Constitution refers to youth as any person aged between 15 and 35 years old. In this research question 'young people' refers specifically to youth engaged in advocacy and supported by the PtY programme. For purposes of this study, the primary focus was put on AGYW segment of young people in line with the vision of the Power to You(th) Consortium which sought to empower adolescent girls and young women (AGYW) from underserved communities to make informed choices, enjoy their sexuality, and to be free from harmful practices in gender-equitable and violence-free societies.

Advocacy: Advocacy is considered as an overall term for policy influencing. This includes inside track of policy influencing approaches – advising and lobbying – as well as the outside track approach of advocacy, i.e. generating information and evidence through research and analysis, a watchdog role, creation of public support for the advocacy and activism.
The next follow-up questions contributed to answering research question 3:

a) What are important competences and resources for advocacy and for holding decision makers accountable, according to young advocates engaged by the PtY programme and experienced advocates in the three countries?
b) How does this compare to the existing competences of AGYW and other young people engaged in the PtY programme and the resources at their disposal?
c) How can the identified gaps be explained?
d) According to AGYW and other young people engaged by the PtY programme, how can the programme best support them in addressing the identified gaps between the necessary competences and resources and the actual competences and resources they have?

CHAPTER TWO: STUDY METHODOLOGY

2.1 Study Design

The study adopted a participatory qualitative research design given the operational nature of the research, which was mainly focused on process learning. Qualitative data collected provided in-depth insights in the perspectives and realities of the communities that PtY worked. In line with the PtY programme's core principle of meaningful and inclusive youth participation, the research was participatory in its essence.

Participatory research methods were geared towards planning and conducting the research process with those people whose life-world and meaningful actions were under study. This meant that programme partners and young people, AGYW in particular, were actively engaged in all research phases. The aim was to produce knowledge in collaboration between trained researchers and practitioners.[7] A participatory approach required choosing methodological approaches in such a way that they built on the initial state of knowledge of the participants and developed it further.[8] Moreover, methods of data collection needed to be appropriate to the concrete research situation and the research partners. Further, the research used communication strategies other than verbal communication, such as using visual and performative methods of data collection and representation.

2.2 Study Area

The study was conducted at both national and county levels. At the county level, the study zoomed into four PtY program counties including Siaya, Homabay, Migori and Kajiado counties. During the co-creation sessions, the various partners identified the following geographical areas of implementation: Kajiado County, Migori County, Siaya County and Homabay County and national level stakeholders. The four counties were the counties where Power to Youth Project currently implements its programs. This selection was based on the fact that these were all patriarchal societies, where decision-making largely lies with the men. Furthermore, all these counties also showed a high prevalence of the key SRHR issues that Power to You(th) addressed. Each of these counties had existing county policies, structures and relationships that CSOs could leverage with the county governments and communities. Finally, all these counties had a presence of active youth-led and youth-serving CSOs. Specifically, the four counties were chosen for the reasons outlined in Table 1 below.

[7] Bergold, Jarg & Thomas, Stefan (2012). Participatory Research Methods: A Methodological Approach in Motion [110 paragraphs]. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 13 (1). Art. 30, http://nbn-resolving.de/urn:nbn:de:0114-fqs1201302. Revised: 4/2016.

[8] Bergold, Jarg & Thomas, Stefan (2012). Participatory Research Methods: A Methodological Approach in Motion [110 paragraphs]. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 13 (1). Art. 30, http://nbn-resolving.de/urn:nbn:de:0114-fqs1201302. Revised: 4/2016.

Table 1: Study Counties

Siaya County	**Background Information** ● High rate of teenage and adolescents' pregnancies ● Disproportionately high SGBV cases amongst the AGYW. In 2018, Siaya County recorded 6.7% SGBVs against the National Percentage of 9.2%
Kajiado County	● High numbers of girls married off before their 18th birthday. The 2014 prevalence rate of child marriage in Kenya is approximately 23% ● Highly patriarchal society where the AGYW have little say on their reproductive health
Homabay County	● High risky cultural behaviors such as disco matanga, sex for fish that has led to high new cases of HIV and teenage pregnancies
Migori County	● High prevalence of Female genital mutilation amongst the Kuria Community ● High prevalence of child marriages and teenage pregnancies ● Widespread SGBV cases which is socially accepted

2.3 Study population

The study participants were purposefully selected from among the following groups: i) young people (with a focus on AGYW); other segments of civil society; iii) duty bearers; and iv) experienced SRHR advocates at national and county levels. The targeted population were drawn from counties and communities where PtY worked. They included both organized youth as well as young people (18-25 years) who were not part of a youth organization or formal network. Although data collection primarily targeted AGYW, it also provided opportunity for involvement of boys and young men. Where participants included young people aged 14 to less than 18 years, arrangements were made with Children's Department to organize the focus group discussions in order to ensure adherence to fundamental ethical principles of research involving young people under 18 years as per the law.

The duty bearers targeted included persons and representatives of institutions that have a particular obligation or responsibility to respect, promote and realize SRHR, whether at community, county or national level. The SRHR advocates were identified within, and in the networks of the PtY organizations through snowball sampling.

2.4 Sampling Strategy

The study adopted a purposive sampling technique to select individuals and groups at various levels with relevant experiences, exposure, and knowledge in matters related to social accountability and SRHR. The purpose was to get respondents who had the capacity to give empirical insights through mainly KII, FGDs and in-depth semi-structured interviews on social accountability in local contexts; effective approaches and tools for promoting accountability in the implementation of Sexual and Reproductive Health and Rights (SRHR) policies; factors affecting social accountability and implementation of SRHR policies; and the priorities and capacity strengthening needs of AGYW in advocating for policy change. The selection criteria also sought to ensure that diverse groups of young people were adequately represented in the research, including young people with disabilities, other disadvantaged groups of youth and young people with compounded vulnerabilities. Table 2 below shows the Study population.

Table 2: Study population and Data Collection Methods

Data Collection Method	Study Participant	Sample
KIIs	County reproductive health coordinators	4 (1 per county)
	Chair –Gender or Legal Affairs Committee in the County Assembly	1 per county
	County Assembly Clerk	1 Per County
	Director Gender/Gender Officers County Government	1 per county
	Representative from county health management team	8 (2 per county)
	PtY programme staff	4 (1 from each implementing partner)
	SRHR advocates	8 (2 Per county)
	Teachers (School head)/Education Officials	4 (1 per county)
	NGEC representative	1 (National level)
	Women Representatives from Counties	4 (1 Per county)
	Representative from the National Anti-FGM Board	1 (National level)
	National Council for Persons with Disability	1 (National level)
	Head, Ministry of Health- Department of Planning and Department of Family Health	2 (National level)
	State Department for Children services	1 (National level)
	SRHR Alliance Representative	1 (National level)
FGDs	AGYW	4 FGDs with 6-12 participants (1 FGD per county)
	Young advocates	4 FGDs with 6-12 participants (1 FGD per county)
	Community Health Promoters	4 FGDs with 6-12 participants (1 FGD per county)
Digital Storytelling	AGYW	6 (1 per county, 2 at national level)

2.5 Data Collection Methods

The study mainly used qualitative methods to collect data from both secondary and primary sources to meet the study objectives. The methods included key informant interviews, focus group discussions, digital storytelling, blogs and diaries as described below.

Desk review: Desk review component entailed review of existing evidence about factors that influence the behavior of people when it comes to holding duty bearers accountable on SRHR (research question 2), as well as evidence about competencies and resources that support effective advocacy (research question 3). Besides research reports and publications, the desk review also involved an analysis of programme documentation, monitoring data and other relevant data available within the programme, including baseline reports; progress

reports; meeting/ activity/ training reports, capacity assessments, as well as relevant data from social media (tweets and other social media posts or conversations). Monitoring data for the programme's outcome indicator 2 ("*description of effective use of accountability mechanisms by citizens/communities and CSOs towards SRHR of all people*") was particularly relevant for the analysis of research question 1.

Key informant interviews: Key informant interviews were held with decision makers and other duty bearers at community, county, and national level. These included National and County Reproductive Health Coordinators; representatives from County Assembly Health Committees from the 4 counties; selected PtY programme staff and other SRHR advocates in the 4 targeted counties. Key informant interview (KII) method was used to collect data for all three research questions using KII guides.

Focus Group Discussions: Focus group discussions (FGDs) were held with AGYW and other groups of (young) people/ communities engaged in the PtY programme including young advocates supported by the PtY programme, and community health promoters. A total of 12 FGDs were conducted. Each FGDs involved 6 to 12 study participants. To ensure effective engagement and contribution of the participants, participatory approaches and tools such as ranking, social mapping and participatory rural appraisal approaches were integrated into the FGDs. Social mapping, in particular, helped to gain insights in power relations and dynamics, which was specifically relevant to research question 2 and 3. The adolescent girls were accessed in schools and colleges. Specifically, the study targeted the adolescents who had participated in Power to Youth activities and trainings. Those who were not in schools or colleges were mobilised by CHPs.

Other Complementary Techniques: Other techniques including digital storytelling were used to complement the main qualitative methods. The final product was a short film, produced and edited by the narrator, using a first person voice in the narration. This was considered an effective method to gain insights on AGYW's experiences, for instance, in respect of the actions they normally take or not take to hold duty bearers accountable, especially the complexity of hindering and supporting factors that influence their behavior (research question 2). Similarly, it helped to gain a better understanding of the capacity strengthening needs and priorities of AGYW and other underprivileged communities (research question 3). Furthermore, blogs were used to record the lived experiences of research participants. From the blogs, the study gathered information on how communities engaged in the programme using accountability mechanisms, or took other actions to hold duty bearers accountable, as well as the circumstances leading up to or following their actions, the challenges they met and factors that supported them.

2.6 Management and Organization of Study

The research team consisted of the Rutgers, PtY partners, young researchers from the diverse communities, together with a research consultant who jointly formed a research team. The research team coordinated closely with the PtY programme's Country Management Team (CMT). Within the research team, the research consultant had the responsibility for guiding the research process and production of the research report and summary. The field team was divided into five national and county teams with three team members each responsible for the national level, Siaya County, Homabay County, Migori County and Kajiado County. All the team members were taken through training in Ciala Resort Kisumu and Homabay.

Amref Health Africa Kenya Country Office provided the leadership. Amref Health Africa together with Siaya Muungano Network, young researchers and the research consultant formed the Kenya research team. Rutgers provided technical support to the research team by sharing relevant tools and supporting the training of young researchers. Amref Health Africa Kenya was responsible for managing the country budgets, including the contracting of consultants and sub-granting to the other partners involved in the study, and for the financial reporting to the Consortium partners.

Rutgers remained the focal organization responsible for quality control during the execution of the COR. Regular check-ins/ debriefs on the process with the research teams and CMT's were held. Rutgers also reviewed the draft reports and participated in validation meetings. Moreover, Rutgers made sure that there were regular feedback loops to the wider partnership, such as updating the Programme's PMELR Technical Working Group, the PtY lab and the Global Management Team (GMT). Rutgers also contributed to the development of knowledge products. This included the production of a consolidated report. Rutgers also contributed to other outputs, in particular visual products, and facilitated the organization of learning events at global level. Finally, as budget holder for the COR of the PtY Programme, Rutgers was responsible for approving the budgets for the study and the dissemination of findings. Table 3 below shows the study team.

Table 3: The Research Team

No.	Name	Role in the Study	Responsibilities
1.	Charles Olwamba	Principal – Investigator	Conceptualization of the study, provides overall leadership of the study
2.	Dorcus Indalo	Co – Investigators from PtY	Conceptualization of the study, establishment of community advisory group, planning for the study activities, training of research assistants (RAs), data analysis, report writing and manuscript development.
3.	Joseph Kokumu	Co-Investigator	Conceptualization of the study, establishment of community advisory group, planning for the study activities, training of research assistants (RAs), data analysis, report writing and manuscript development.
4.	Dr Charles Oyaya	Co-Investigator (Research Consultant)	Conceptualization of the study, establishment of community advisory group, planning for the study activities, training of research assistants (RAs), data analysis, report writing and manuscript development.
5.	Dr Martin Muchangi	Co-Investigator	Conceptualizing the study, providing technical advice, proposal writing, review of report
6.	Shirleen Otieno	Co - Investigator	Planning of the study activities, Report writing, Training of the Research Assistants, development of Knowledge materials

7.	Maureen Rovinnah	Co-Investigator	Conceptualizing the study, Data collection, data management, Report writing
8.	Ericah Okeyoh	Co-Investigator (Young Researcher)	Conceptualizing the study, desk review, Data collection, data management, Report writing
9.	Basil Owiti	Co-Investigator (Young Researcher)	Conceptualizing the study, desk review, Data collection, data management, Report writing
10.	Joyce Naisola	Co-Investigator (Young Researcher)	Conceptualizing the study, desk review, Data collection, data management, Report writing
11	James Kasaine	Co- Investigator (Young Researcher)	Conceptualizing the study, desk review, Data collection, data management, Report writing
12	Lydia Hongo	Co- Investigator (Young Researcher)	Conceptualizing the study, desk review, Data collection, data management, Report writing
13	Martina Onyango	Co- Investigator (Young Researcher)	Conceptualizing the study, desk review, Data collection, data management, Report writing
	Harald Kedde	Rutgers Collaborator	Technical support, Quality control
	Loes Loning	Rutgers Collaborator	Technical support, Quality control

2.7 Quality Assurance and Data Management

Appropriate arrangements were put in place to assure the quality of the data collected from KIIs, FGDs and in-depth interviews. As a matter of procedure, initial manual editing was undertaken by the county research teams. The supervisors further checked and validated the data from each team. All the data was then processed through coding of open-ended questions and then data entry, cleaning and analysis by the team in a workshop. Recordings of KII, FGD and other relevant discussions (used in visual or performative methods for instance) was securely stored at the Amref Health Africa offices in Nairobi, Kenya. Additionally, relevant information from the desk review and from reports and notes from other data collection methods were documented and stored in password protected folders. No names and other identifying information were included in any of the transcripts/ documents.

2.8 Ethical Considerations

In the first instance, the study sought and received research permit and ethical approval from the National Commission for Science, Technology and Innovation (NACOSTI) and the Amref Health Africa ESRC respectively, prior to data collection. The study further adhered to the Amref Health Africa Safeguarding Policy. Within the context of the PtY Programme, safeguarding refers to measures taken to protect the health, well-being and human rights of individuals, which allow people, especially children, young people and vulnerable adults to live free from sexual exploitation, abuse and harassment (SEAH) as well as protection against financial violations, specifically fraud. Sexual exploitation, abuse and harassment includes all forms of unfair discrimination on the basis of sex and/or gender and/or sexual orientation which infringe on the rights of the complainant and constitute a barrier to equity in the

workplace, including the communities where the PtY programme and COR are implemented. In addition, the study adhered to the PtY programme core principles including Southern Leadership and Meaningful and Inclusive Youth Participation. The study also adhered to the three fundamental ethical principles of research involving human subjects:

a) *Respect for persons*, which includes the protection of autonomy of research participants and allowing for informed consent;
b) *Beneficence*, which includes maximizing the benefits that accrue to research participants and minimizing risks to the research subjects ("Do no harm"); and
c) *Justice*, which includes ensuring a fair distribution of the risks and benefits resulting from research.

All persons involved in the study process were inducted to abide by the rules of ethical research. The principle of voluntary consent to ensure that every respondent willingly participated in the process was upheld. Each individual participating in the research as a respondent was asked for his or her written informed consent prior to their participation. Adequate provisions were made for those who could not read.

To guarantee confidentiality, all participants were given code names in the data collection, analyses and reporting. Consent forms were stored separately to ensure that identifying information cannot be linked. Participants' names were anonymized in all research outputs unless people explicitly agreed to be named. Participants were explicitly given the opportunity to decide that specific information be excluded from data analysis or not reported, at any time during the research process.

In the process of data collection, adequate care was taken to acknowledge sources of information and not to fake data and their sources. The results of the study were presented and reported in the most open, objective, accurate and honest manner while recognizing the freedom of exchange of ideas and information. The role and intellectual contributions of various persons involved in the design, analysis and development process were also dully acknowledged.

2.9 Data analysis

In view of the participatory nature of the COR, data analysis was conducted by the research team with diverse young people participating as co-researchers and data analysts. This ensured that the various perspectives flew into the interpretation during the data analysis process and that the research team members gained useful insights in data analysis, interpretation and report writing.

Qualitative information gathered from the key informants, FGD and literature review were compiled and analyzed according to source and themes. The qualitative data was both manually analyzed using content analysis techniques and MAXQDA software. As a first step of the data analysis, each team summarized the findings from interviews and coded all the data. To facilitate the data coding, a data analysis workshop was organized for the research team. This process facilitated the learning and ownership of those involved and enhance the quality of the interpretation. Information from various sources was then organized, summarized, categorized and triangulated according to research questions and objectives of the study. The findings were presented and discussed in a validation session involving a wider group of programme stakeholders.

2.10 Dissemination of research findings

Central to the study, was the dissemination of research findings to various audiences including PtY consortium members, country partners, decision-makers and other duty-bearers, youth-led organizations, communities, CBOs, NGOs, youth advocates, communities of practice and researchers working in the field of SRHR at various levels. To this end, the research teams produced a user-friendly research report and summary as well as other knowledge products including peer reviewed journal articles and policy and advocacy briefs. In addition, innovative and user-friendly outputs were produced including cartoons, blogs, vlogs, short films, or photo/ art expositions. The study findings were also disseminated through social media spaces to partners and community members.

2.11 Study limitations

The main limitation of the study was the challenge of getting appointments with some duty bearers and decision makers for the interviews within the time assigned for data collection. This led to delays in completing filed work in all the four study counties and at the national level. Budgetary limitation was also a key constraint. These were addressed by revision of the work plan and budget lines without affecting the overall quality of delivery of the research outputs.

CHAPTER THREE: SOCIAL ACCOUNTABILITY AND COMMUNITY ENGAGEMENT IN THE CONTEXT SEXUAL AND REPRODUCTIVE HEALTH RIGHTS (SRHR)

3.1 Introduction

This chapter presents an overview of the dynamics and factors of social accountability in adolescent and young women's SRHR.

3.2 Dynamics of social accountability in adolescent and young women's SRHR

Social accountability is increasingly proffered as a key strategy to addressing health systems inefficiencies and improving planning, service delivery and health system performance towards the widest possible enjoyment of the health rights. Civil society organizations in particular see social accountability as one key approach to improving the realization of Sexual and Reproductive Health and Rights (SRHR).[9] The 2008 Accra Agenda for Action[10] and the 2005 Paris Declaration on aid effectiveness[11] emphasized the country's ownership of development policies through social accountability and citizen engagement.

While social accountability is highly preferred as a panacea to promoting SRHR, there is however little evidence on its programmatic impact.[12] In most cases, the assumption of social accountability is that elected governments, from ministries to service providers, have a duty to their citizens, and citizens have the right to hold their representatives accountable for their duties.[13]

Broadly, social accountability refers to ongoing and collective effort[s] to hold public officials to account for the provision of public goods which are existing state obligations."[14] Social accountability is also referred to as "citizens' efforts at ongoing meaningful collective engagement with public institutions for accountability in the provision of public goods.[15] According to the World Bank, social accountability is "an approach towards building accountability that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organizations who participate directly or indirectly in exacting accountability.[16] Social

[9] Victoria Boydell, Heather McMullen, Joanna Cordero, Petrus Steyn and James Kiare (2019), Studying social accountability in the context of health system strengthening: innovations and considerations for future work, Health Research Policy and Systems (2019) https://doi.org/10.1186/s12961-019-0438-x

[10] AFDB (2008), Accra Agenda for Action, 3rd High Level Forum on Aid Effectiveness, September 2-4 2008, Accra, Ghana. https://www.afdb.org/fileadmin/uploads/afdb/Documents/AccraAgendaAaction-4sept2008-FINAL-ENG_16h00.pdf

[11] OECD (2005), The Paris Declaration on Aid Effectiveness, Second High Level Forum on Aid Effectiveness, 2nd March 2005, Paris, France. https://web-archive.oecd.org/temp/2021-08-02/73869-parisdeclarationandaccraagendaforaction.htm

[12] Schaaf, M., Arnott, G., Chilufya, K.M. *et al.* Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations. *Int J Equity Health* **21** (Suppl 1), 19 (2022). https://doi.org/10.1186/s12939-021-01597-x

[13] IPPF (2013) A Guide to Using Community Score Cards for Youth-Led Social Accountability

[14] Houtzager P, Joshi A. Introduction: contours of a research project and early findings. IDS Bull. 2008;38(6):1–9. doi: 10.1111/j.1759 5436.2007.tb00413.x. [CrossRef] [Google Scholar]

[15]Joshi A. Legal empowerment and social accountability: complementary strategies toward rights-based development in health? World Dev. 2017; 99:160–72.

[16] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

accountability includes a broad range of actions and mechanisms which rely on civic engagement which citizens can use to hold the state and duty bearers accountable.[17] Social accountability mechanisms complement and enhance conventional internal government mechanisms of accountability like internal audit units and quality assurance departments in health systems by providing a set of tools that young people can use to influence the quality of health service delivery by holding providers accountable.[18]

Social accountability is thus a citizen-led action to hold public officials and service providers to account for the use of public resources and services delivered. It provides an avenue for citizens to exercise their constitutional right to participate in decisions and processes concerning their own development.[19] It is a process and an approach in which citizens are engaged to hold leaders, policymakers, and public officials accountable for the services that they provide. It enables ordinary citizens or civil society organizations to participate directly or indirectly in demanding accountability.

Social accountability is an advanced form of community participation whereby citizens take action to enhance the accountability of politicians, policymakers and service providers. A key area of accountability is government or public accountability- a form of accountability builds on the implicit social contract between citizens and their delegated representatives. It is the obligation of power-holders to account for or to take responsibility for their actions. Social accountability processes are critical in ensuring that government services are delivered as planned and budgeted are of quality and good value for money for citizens.[20] Social accountability can play an important role in addressing corruption and increasing trust in public servants and government, which is key to accelerating efforts to achieve the Sustainable Development Goals (SDGs) and increasing the power and influence of citizens on agenda-setting.[21]

Social accountability interventions typically entail citizens and community actors assessing government performance against an agreed set of standards. They involve citizens and CSOs in public decision making; enables citizens and CSOs to articulate their needs to governments and service providers; brings the perspective of citizens and CSOs to government activities, such as policy making, the management of public finances and resources, and service delivery; and allows civil society to participate in monitoring the public sector and giving feedback on government performance. They also involve a deliberative consensus building or priority setting process, wherein community members discuss and identify priorities; two-way dialogue between communities and the health system about these priorities; and follow up to ensure that these priorities are addressed.[22]

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[17] World Bank (2004), Social Development Papers: Participation and Civic Engagement Paper No. 76 December 2004, World Bank.
[18] Dena Ringold, Alaka Holla, Margaret Koziol, Santhosh Srinivasan (2012) Citizens and Service Delivery: Assessing the Use of Social Accountability Approaches in the Human Development Sectors.
[19] Ahadi, Social Accountability, County Governance Toolkit. https://countytoolkit.devolution.go.ke/social-accountability
[20] Ahadi, Social Accountability, County Governance Toolkit. https://countytoolkit.devolution.go.ke/social-accountability
[21] McDougall, L. (2016). Power and Politics in the Global Health Landscape: Beliefs, Competition and Negotiation Among Global Advocacy Coalitions in the Policy-Making Process. International Journal of Health Policy and Management, 5(5), 309–320. https://doi.org/10.15171/ijhpm.2016.03
[22] Marta Schaaf, Grady Arnott, Kudzai Meda Chilufya, Renu Khanna, Ram Chandra Khanal, Tanvi Monga, Charles Otema, and Christina Wegs (2022), Social accountability as a strategy to promote sexual and

Since social accountability is explicitly concerned with changing the power relationship between 'citizens' and the duty-bearers, the use of social accountability tools are inherently political even if they do not intend to be and hence can never be neutral.[23] Social accountability processes therefore aim to support service users to voice their needs, make claims to their entitlements and hold those responsible for the provision of services to account.[24]

In the context of healthcare, social accountability is a form of participatory citizen engagement where citizens are recognized as service users who are impacted by healthcare decisions, and as a consequence, they can effect changes in healthcare policies, healthcare services, and/or healthcare provider behavior through their collective influence and action.[25] However, in many instances, community participation, especially among women in accountability processes is fragmented.[26]

Social accountability processes feature multiple and interrelated components, steps and actors, with several simultaneous processes of triggering collective changes.[27] The social accountability processes share three broad components as a part of their theory of change, namely information, collective action and official response.[28] The key common building blocks of social accountability include obtaining, analyzing and disseminating information, mobilizing public support, and advocating and negotiating change. The citizen-driven accountability measures complement and reinforce conventional mechanisms of accountability such as political checks and balances, accounting and auditing systems, administrative rules and legal procedures.[29] Broadly social accountability is based on three key principles, namely transparency, accountability and participation as shown in the Figure 2 below.

reproductive health entitlements for stigmatized issues and populations, International Journal on Equity Health. 2022; 21(Suppl 1): 19.

[23] Victoria Boydell, Heather McMullen, Joanna Cordero, Petrus Steyn and James Kiare (2019), Studying social accountability in the context of health system strengthening: innovations and considerations for future work, Health Research Policy and Systems (2019) https://doi.org/10.1186/s12961-019-0438-x

[24] Joshi A. Legal empowerment and social accountability: complementary strategies toward rights-based development in health? World Dev. 2017; 99:160–72.

[25] Fox, J. A. (2015). Social Accountability: What Does the Evidence Really Say? World Development, 72, 346–361. https://doi.org/10.1016/j.worlddev.2015.03.011

[26] Hoope-Bender, P., Martin Hilber, A., Nove, A., Bandali, S., Nam, S., Armstrong, C., Ahmed, A. M., Chatuluka, M. G., Magoma, M., & Hulton, L. (2016). Using advocacy and data to strengthen political accountability in maternal and newborn health in Africa. International Journal of Gynecology & Obstetrics, 135(3), 358–364. https://doi.org/10.1016/j.ijgo.2016.10.003

[27] Moore GF, Audrey S, Barker M, Bond L, Bonell C, Hardeman W, et al. Process evaluation in complex public health intervention studies and the need for guidance. J Epidemiol Community Health. 2014; 68(2):101–2. https://doi.org/ 10.1136/jech-2013-202869.;

[28] Joshi A. Do they work? Assessing the impact of transparency and accountability initiatives in service delivery. Dev Policy Rev. 2013; 31:29–48.

[29] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

Figure 2: Social accountability principles and approaches.

Transparency	Accountability	Participation
Transparency & Information o Information Campaigns o Citizen Charters o Citizen Service Centers **Budget Transparency** o Public Reporting of Revenues & Expenditures o Citizen's Budget o Budget Literacy Campaigns o Public Expenditure Tracking o Independent Budget Analysis	**Monitoring by Non-State Actors** o Community Scorecard o Social Audit o Citizen Report Card o Citizen Satisfaction Survey **Grievance Redress** o Formal Grievance Redress Mechanism o Citizens' Jury	**Consultations** o Public Hearings o Focus Group Discussions o Advisory Body/Committee **Participatory Planning, Management & Decision Making** o Participatory Planning o Community Management o Community Contracting o Citizen/User Membership in Decision-Making Bodies o Citizens' Jury **Participatory Procurement & Financial Management** o Procurement Monitoring o Public Expenditure Tracking o Integrity Pacts o Participatory Budgeting

Source: World Bank, Social Accountability E-Guide

Social accountability involves a broad range of actions, mechanisms and tools that citizens, communities, independent media and civil society organizations can use to hold public officials and public servants accountable and to trigger change.[30] These include community scorecard, social audits, citizen scorecard, gender budgeting, public expenditure tracking, public hearings, participatory planning and budgeting, audio-visual documentation of rights violations, monitoring of public service delivery, investigative journalism, public commissions and citizen advisory boards and citizen charters among others.

Social Accountability tools such as whistle-blower mechanisms, public hearings, and consultation, online and social media advocacy, complaints and feedback mechanisms, and open data platforms, empower communities and individuals to actively participate in governance and hold institutions accountable for their actions. The social accountability mechanisms and tools may vary in focus, looking either broadly at health systems or focusing on specific service delivery points, and they vary in engagement type from collaborative problem solving to more adversarial approaches.

These social accountability mechanisms and tools can contribute to improved governance, increased development effectiveness through better service delivery, and empowerment. In addition, the use of social accountability mechanisms and tools can - enhance awareness, understanding, and appreciation among communities; invoke participatory decision making between rights holders & service providers; promote shared responsibility; help track resources, allocation and their utilization; promote ownership and leadership by communities in development of their communities; help service providers understand community needs better; and promote understanding of community perceptions on quality and timeliness of services.

[30] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

3.3 Inclusion in social accountability processes

Social accountability interventions are undertaken in the context of social structures, multiple strata of power, power dynamics and accountability relations within the health system and society in general, which may serve to diminish or exclude certain voices in society.[31]

Despite one of the objectives of social accountability being to enhance and make the voices of the vulnerable and marginalized to be heard, studies have shown that challenges in ensuring inclusion and equity in social accountability efforts are shaped by the politicization, social traditions, and stigma attached to, for example, SRHR matters.[32] Values, norms, and judgements related to issues such as single motherhood, sexuality, and fertility may influence provider and policy-maker attitudes regarding key SRHR issues, as well as the quality of care provided.[33]

Deliberative social accountability processes are also sometimes dominated by members of the community who have the most power thereby marginalizing especially vulnerable and marginalized groups – who often may face significant risk and repercussions in speaking out.[34] In addition, vulnerable and marginalized individuals may be unwilling to articulate their concerns in contexts where collective action among particular groups is unsafe and responsiveness by the state is unlikely.[35] For example, a study in Kibuku District–Uganda found that recently pregnant adolescents were unlikely to participate in or benefit from the community scorecard project because of a number of reasons including: stigmatizing and rude treatment by health providers; inconveniently timed meetings; the adolescents feeling uncomfortable discussing their own pregnancy; and the priorities arising from community meetings not including their particular challenges.[36] These findings point to the failure of some social accountability programs to take into account social and power dynamics to support engagement from community members who feel unsafe or unable to speak.[37] As a result, the priorities identified may not reflect the needs or priorities of those who are the most harmed by the status quo.[38]

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[31] George A. Using accountability to improve reproductive health care. *Reprod Health Matters.* 2003;11:161–170. doi: 10.1016/S0968-8080(03)02164-5.

[32] Boydell V, Schaaf M, George A, Brinkerhoff DW, Van Belle S, Khosla R. Building a transformative agenda for accountability in SRH: lessons learned from SRH and accountability literatures. Sex Reprod Health Matters. 2019;27:64–75. doi: 10.1080/26410397.2019.1622357.

[33] Marta Schaaf, Grady Arnott, Kudzai Meda Chilufya, Renu Khanna, Ram Chandra Khanal, Tanvi Monga, Charles Otema, and Christina Wegs (2022), Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations, International Journal on Equity Health. 2022; 21(Suppl 1): 19

[34] Dasgupta J. Ten years of negotiating rights around maternal health in Uttar Pradesh, India. BMC Int Health Hum Rights. 2011; 11:1–1. doi: 10.1186/1472-698X-11-S3-S4.

[35] Dasgupta J. Ten years of negotiating rights around maternal health in Uttar Pradesh, India. BMC Int Health Hum Rights. 201; 11:1–1. doi: 10.1186/1472-698X-11-S3-S4.

[36] Apolot RR, Tetui M, Nyachwo EB, Waldman L, Morgan R, Aanyu C, Mutebi A, Kiwanuka SN, Ekirapa E. Maternal Health challenges experienced by adolescents; could community score cards address them? A case study of Kibuku District–Uganda. Int J Equity Health. 2020;19:1–2. doi: 10.1186/s12939-020-01267-4.

[37] Bennett S, Ekirapa-Kiracho E, Mahmood SS, Paina L, Peters DH. Strengthening social accountability in ways that build inclusion, institutionalization and scale: reflections on FHS experience. Int J Equity Health, 2020;19:1–6.

[38] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

Other common challenges in social accountability programs relating SRHR, include financing and budgetary constraints; risk of social and physical harm perpetrated by household members, community members, or health system actors; inability to meaningfully address issues that are perceived to be beyond the authority of the program participants; stigma and harmful gender norms among providers and communities; and lack of clear guidance, authority, and knowledge of SRH entitlements at local level. There is also the general lack of programmatic evidence base on if, when, and how social accountability strategies can be used to promote access to quality sexual and reproductive health (SRH) care for stigmatized populations and/or stigmatized issues.[39] To ensure social accountability efforts are inclusive both in terms of populations and issues addressed, programs need to address stigmatize and discrimination issues and advocate for enabling legal framework. Inclusion should also be built into the program design, permeating all stages of implementation.[40]

3.4 Factors in social accountability

The success of a social accountability process encompasses more than directly measurable health-related outcomes and includes a wider range of governance outcomes such as empowerment, participation, and the responsiveness of duty-bearers.[41] Critical factors of success include access to and effective use of information, civil society and state capacities and synergy between the two.[42] However, evaluating the success of a social accountability process could be methodologically challenging especially with regards to defining the boundaries of interventions and outcomes of interest and the appropriate evaluation design and methodological approach. According to Joshi (2017), the expanding number of outcomes related to social accountability "are expected to unfold, and range from immediate short-term improvements in public services, to more durable long-term changes in states and societies."[43] It is also notable that for the social accountability mechanisms and tools to be effective on the long run, they need to be institutionalized and linked to existing governance structures and service delivery systems.[44]

In the context of sexual and reproductive health and rights, there are a variety of factors that affect or impact how social accountability and community participation for young girls and women are exercised. These include - gender norms around participation; citizen engagement

[39] Marta Schaaf, Grady Arnott, Kudzai Meda Chilufya, Renu Khanna, Ram Chandra Khanal, Tanvi Monga, Charles Otema, and Christina Wegs (2022), Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations, International Journal on Equity Health. 2022; 21(Suppl 1): 19

[40] Marta Schaaf, Grady Arnott, Kudzai Meda Chilufya, Renu Khanna, Ram Chandra Khanal, Tanvi Monga, Charles Otema, and Christina Wegs (2022), Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations, International Journal on Equity Health. 2022; 21(Suppl 1): 19.

[41] Victoria Boydell, Heather McMullen, Joanna Cordero, Petrus Steyn and James Kiare (2019), Studying social accountability in the context of health system strengthening: innovations and considerations for future work, Health Research Policy and Systems (2019) https://doi.org/10.1186/s12961-019-0438-x

[42] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

[43] Joshi A. Legal empowerment and social accountability: complementary strategies toward rights-based development in health? World Dev. 2017; 99:160–72.

[44] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

in governance; education and awareness; cultural awareness; availability of information and services; gender equality and empowerment; and reduction of stigma.

It is therefore highly recommended that there be a comprehensive community based SRHR education programs to facilitate the community with the relevant information they need about sexual and reproductive health and rights. Peer education would further encourage adolescent girls and young women to share and open up with their peers and not to isolate themselves when they need assistance regarding their sexual and reproductive health. Non- governmental organizations that work with young people should also employ social media as a tool to spread awareness about sexual health. Lastly, given the high rates of depression and suicide among adolescents, mental health support should be facilitated to equip young women with the confidence to face their day-to-day challenges in sexual health.

3.5 Barriers to social accountability

In sub-Saharan Africa, concerns have been raised regarding the quality of healthcare including sexual and reproductive healthcare services delivered and their outcomes.[45] Existing healthcare system bottlenecks such as drug shortages, disrespect of patients in public healthcare facilities, and healthcare workers' focus on donor-funded activities are among the factors that affect healthcare service functioning in sub-Saharan African countries.[46] Other barriers include cultural norms; inadequate representation of AGYW in decision making; power imbalances; stigma and discrimination; limited access to SRHR education and information; economic constraints; limited access to technology or digital platforms; inadequate or lack of enabling institutional mechanisms for meaningful engagement and participation of AGYW in social accountability processes; and security and safety challenges.

These challenges underline the need to improve knowledge and attitude change among adolescent girls and young women on sexual and reproductive health and rights aspects and to develop a more structured model for training AGYW as role models, Ambassadors, Mentors, etc. and putting in place referral mechanisms for access to justice and reporting.

[45] Warren, A. E., Wyss, K., Shakarishvili, G., Atun, R., & de Savigny, D. (2013). Global health initiative investments and health systems strengthening: A content analysis of global fund investments. Globalization and Health, 9(1), 30. https://doi.org/10.1186/1744-8603-9-30

[46] Danhoundo, G., Nasiri, K., & Wiktorowicz, M. E. (2018). Improving social accountability processes in the health sector in sub-Saharan Africa: A systematic review. BMC Public Health, 18(1), 497. https://doi.org/10.1186/s12889-018-5407-8

CHAPTER FOUR: STUDY FINDINGS

4.1 Introduction

The study sought to gain a comprehensive understanding of social accountability in local contexts and to identify effective approaches and tools for promoting accountability in the implementation of Sexual and Reproductive Health and Rights (SRHR) policies. The study also assessed the sexual and reproductive health (SRH) needs and interventions for adolescent girls and young women (AGYW) and the factors that promote accountability in the implementation of Sexual and Reproductive Health and Rights (SRHR) policies. This Chapter presents the results of the assessment in the four PtY programme counties, namely Kajiado, Saiya, Migori, and Homabay.

4.2 Assessment of the sexual and reproductive health needs and interventions within the community

4.2.1 Key adolescent and young people's SRH needs, issues and priorities in the community.

With respect to the major SRH problems/issues that AGYW face within their communities, the respondents across the board including AGYW, youth advocates, community health workers and representatives, county reproductive health leaders, teachers and education officials at local community, county, and national levels identified the following key problems:

a) *Lack of free access to services on sexual and reproductive health services* - The nearby facilities, do not have adolescent and youth friendly services and this makes them to fear accessing these services as the people offering the services are older yet they need a sensitive and friendly environment.
b) *Traditional cultural and religious practices such as* FGM harm AGYW's physical and mental health.
c) Regulations by the ministry of Education barring comprehensive sex education in schools.
d) *Unreliable Information Sources*: AGYW primarily rely on peers, social media, and to a lesser extent, schools and community health promoters (CHPs) for SRHR information. The accuracy and reliability of information from peers and social media are often questionable.
e) *Limited Knowledge due to* lack of comprehensive sexuality education (CSE) leading to school drop-out, and increased vulnerability to unintended pregnancies, sexually transmitted infections (STIs), and HIV.
f) *Retrogressive practices and norms expect* young people not to talk about sex or to mention sex.
g) *Limited access to SRHR information and services due* to stigma and distance to facilities.
h) *Sexual and Gender-Based Violence (SGBV)* hindering AGYW health and well-being.

When asked about the key SRH needs of AGYW in the community, the respondents across the four counties identified several needs including the following:

a) *Improving access to comprehensive information and education*: The respondents pointed out an existing knowledge gap regarding healthy sexual behavior. The respondents emphasized the need for age-appropriate CSE in schools such as teaching AGYW on reproductive health, safer sex, preventing early pregnancies, and using condoms to prevent infections on sexual and reproductive health system. Stressing the significance of improving AGYW's access to SRHR information, a key informant in Homabay stated:

> *"They are in need of contraceptives and information. Information should be given a priority, because when they have adequate information then they can be able to make informed choices." KII, Homabay*

b) *Accesses to services*: The respondents identified affordability and accessibility of sexual and reproductive health services as a major challenge. This included high costs, geographical barriers, and a lack of youth-friendly healthcare facilities as key barriers preventing AGYW from accessing essential services like family planning, antenatal care, safe delivery, and post-partum care.
c) *Addressing harmful practices such as FGM, child marriage, teenage pregnancy &, etc.*: FGM remains a public health concern in some communities, especially within Migori and Kajiado Counties. The physical and psychological consequences of FGM necessitate a multi-faceted approach that addresses cultural norms, empowers girls to refuse the practice, and provides support to survivors. Teenage pregnancy was also identified as a major concern due to a lack of ready access to family planning services and comprehensive SRHR education.
d) *Creating a supportive policy and legislative framework or harmonized policy*: The respondents pointed out the need to create supportive policies & legislative frameworks, especially at the county level to guide the provision and access to sexual and reproductive health services and information for adolescent girls and young women.
e) *Capacity Building*: The respondents identified the need for capacity-building programs to empower AGYW to understand their rights, challenge harmful cultural practices such as FGM, and hold leaders accountable. For example, the National Chair for Gender Sector Working Group pointed out, that misconceptions about sexuality education persist, with many people erroneously viewing it as promoting youth sexual activity instead of awareness creation.
f) *Need of Youth-friendly health facilities among these counties*: Lack of adolescent and youth-friendly healthcare facilities was identified as a major barrier to AGYW in accessing SRHR information and services.
g) *Gender Inequality and Empowerment*: Deeply entrenched gender norms and power imbalances within families and communities restrict AGYW's choices regarding their SRHR. Cultural expectations around virginity, pressure for early marriage, and limited decision-making power all contribute to this challenge.

Asked about what they considered as priority areas of interventions in response to the AGYW's SRH needs, issues, and challenges, the respondents across the board at the community, county, and national levels identified the following:

a) *Comprehensive community based Sexuality Education (CSE):* Equipping AGYW with knowledge of their bodies, relationships, and SRHR is crucial. Also ensuring access to quality information through community education on sexual reproductive health and

uptake of antenatal care services. *"We should prioritise community education on sexual reproductive health." KII_ Director Commodities and Technologies, Homabay*

b) *Correct and accurate information:* Accurate information for AGYW in terms of sexual reproductive services, and reproductive health information, including addressing the "triple threat" of teenage pregnancy, HIV, and gender-based violence.
c) *On policy and legislation*- By developing supportive policies and legislation that enable the provision of these services while meaningfully engaging young people.
d) *Education and Awareness:* Prioritize SRHR education campaigns to address knowledge gaps and empower AGYW to make informed choices.
e) *Capacity Building*: Invest in workshops and training sessions for AGYW to understand their rights and challenge harmful practices.
f) *Knowledge and Advocacy*: AGYW in the county lack sufficient knowledge to engage leaders on SRHR issues due to limited access to accurate SRHR information and Cultural stigma surrounding discussions of sexuality.

4.2.2 Respondents' understanding of SRHR

When asked about what sexual and reproductive health rights (SRHR) was about, the respondents across the board including AGYW, youth advocates, community health workers and representatives, county reproductive health leaders, teachers and education officials at local, county, and national levels variously described what they considered as SRHR. They said that SRHR includes access to the right SRHR information, appropriate services of SRH, and freedom to make autonomous decisions about one`s sexuality, sexual activity, and reproduction without fear of stigma or discriminations. In addition, they pointed out that SRHR is about enabling individuals with information and knowledge regarding sexual reproductive health and rights.

Specifically, the respondents stated that SRHR encompasses physical, mental, emotional, and social wellbeing related to sex, sexuality, pregnancy, childbirth, and family planning, while also emphasizing the importance of knowledge, social accountability, and equitable frameworks that govern access to sexual and reproductive health resources. The respondents also understood SRHR as a holistic approach to empowering individuals of all genders and ages to make informed decisions about their sexuality, reproduction, and overall sexual and reproductive wellbeing, including through access to comprehensive healthcare services, understanding one's own sexuality, addressing SRHR at individual and community levels, and ensuring justice and support for survivors of sexual violence.

Broadly, the respondents description of SRHR aligns with the comprehensive definition of SRHR proposed by the Guttmacher–Lancet Commission,[47] which includes access to full, comprehensive sexual and reproductive health that can change the course of a person's life and set them up to reach their full potential [48]as shown in Figure 3 below.[49]

[47] Starrs, Ann, and others (2018). Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet, vol. 391, pp. 1642–92

[48] Leah Rodriguez (2021) What Is SRHR? Everything to Know About Sexual and Reproductive Health and Rights, Global Citizens, October 22, 2021. https://www.globalcitizen.org/en/content/sexual-reproductive-health-rights-srhr-explained/

[49] UNFPA (2019), Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage, Background document for the Nairobi summit on ICPD25 – Accelerating the promise. United Nations Population Fund, November 2019. https://www.unfpa.org/sites/default/files/ pub-pdf/SRHR_an_essential_element_of_UHC_SupplementAndUniversalAccess_27-online.pdf

Figure 3: A comprehensive definition of sexual and reproductive health and rights

Source: UNFPA 2019, Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage.

4.2.3 AGYW Capacity to engage leaders and policymakers on SRHR issues

In Migori county, the AGYW interviewed appeared well informed because of the training and capacity building for young people on how to engage their leaders on matters of social responsibility through "Tunaweza Empowerment Organization (TEO)". The Tunaweza Empowerment Organization provides capacity building to young people especially guiding and training them on advocacy, development and submission of memorandums, petitions and position papers to the duty bearers. However, in other counties most of the AGYW interviewed expressed a lack of capacity to effectively and meaningfully engage leaders and policy makers on SRHR matters. This was because of various reasons, including:

a) Lack of information, awareness, and capacity building on the importance of engaging leaders and policy makers including the level at which the AGYW can best engage the policy makers and the leadership to come up with enabling policies or to make

decisions favorable for their increased access to SRH services as well as promotion of their sexual reproductive health rights.

b) In some counties such as Kajiado, AGYW expressed general lack of awareness of the existing platforms and mechanisms to engage leaders on SRHR issues. They also pointed out that on rare occasions policy makers or duty bearers engage AGYW directly when formulating some of the policies that are geared towards creating an environment for better access to reproductive health services and information. In Migori county, AGYW expressed difficulties in accessing the budget documents such as the county fiscal strategy paper, which show different allocations as per projects. In most cases, access to this kind of information is not easy perhaps because of lack of clear pathways for involvement and representation of young people especially AGYW in the government affairs.
c) The existing structures of engagement such as the County Budget and Economic Forums (CBEF) are not conducive and favorable for the AGYW and such structures do not promote meaningful engagement. The County Budget and Economic Forums (CBEFs) are set-up to coordinate and collect views from the public during the budgeting process and function as think-tanks for the county governments in terms of financial and economic management. For example, the composition CBEFs do not explicitly provide for representation of young people. It provides for an equal number of non-state members drawn from organizations including those representing professionals, business, labour issues, women, persons with disabilities, the elderly and faith based groups at the county level.[50]
d) Lack of well-defined channels for AGYW to access SHRH information was reported as a factor affecting their ability and capacity to engage meaningfully with leaders and policy makers and to holding them to account from an informed position. Meaningful engagement with the duty bearers requires unhindered access to information as well as good and clear communication channel.
e) AGYW have limited opportunities and capacity to effectively engage the duty bearers on policy formulation and decision making. This was partly attributed to the fact that AGYW often have limited access to information on technical documents such as budget documents. They are also not adequately represented in various decision making structures and social accountability processes at the county level.
f) Some young women fear approaching leaders due to social norms and power imbalances. In areas where patriarchy remains entrenched, women and young people have limited opportunities to directly engage their leaders in decision making.

To bridge the capacity gaps in AGYW's engagement with leaders and policymakers on SRHR issues, the respondents suggested the following:

a) Continuously bring adolescents and young people up to speed on the relevant and current SRHR issues and opportunities for influencing decisions. As a key informant at National Council for Population and Development (NCPD) stated:

> " *Engage with young people in schools and colleges while they are still students start with under 25, extending the outreach to those above 25, providing education, mentorship, to meaningfully engage in decision-making arenas." (KII, NCPD)*

[50] Commission on Revenue Allocation (u.d.), Guidelines for Formation and Functioning of CBEF. https://countytoolkit.devolution.go.ke/sites/default/files/resources/CBEF-Guidelines-ORIGINAL.pdf

b) Build the capacity of AGYW through organized groups of young people both within the school and community ecosystems and create a safe space where policy makers can meet and talk to them. The safe space should guarantee privacy, confidentiality, access and safety for the AGYW. It entails having an environment where the AGYW can come together and discuss their issues without any fear of discrimination or fear of being judged. For example, the "Husika Dada" provides a platform for AGYW in Siaya where they are able to have discussions on different issues such as SRHR policy issues, develop and submit memoranda to the duty bearers and also do follow ups.

> *"The principle is nothing for us without us, adolescent girls and young women are at the center point of some of the reproductive health needs and we need to have consultative forums to get their voices on what works for them." KII - PtY staff.*

c) Sensitize young people on policy-making avenues, procedures, and processes, how stakeholders engage with duty bearers to come up with policies, decisions, and plans, how they are influenced and the effect of policies on their rights.

It is however, noteworthy that the above suggestions state something that can be done for AGYW to act differently e.g. bringing them up to speed, building capacity, sensitizing them, providing access to information. But they fall short of indicating what leaders and policy makers should do differently to enable AGYW fully enjoy their SRHR. The suggestions appear to place greater responsibility on young people to bridge the capacity gaps. It would therefore be critical to advocate for changes in the existing mechanisms and pathways of engagement for the AGYW in the SRHR space at all levels of decision making.

4.2.4 Sources of information and key platforms for the AGYW to discuss SRHR matters

Although access to information remained a major challenge, when asked about the main sources of SRHR information for the AGYW, the respondents pointed out that most AGYW access information on SRHR from a variety of sources including:

a) Through guidance and counseling department in schools and colleges. All schools and colleges in Kenya are required to have in place Guidance and Counselling Departments. Guidance and counselling services in schools play a vital role in ensuring that students receive a holistic education that prepares them for the challenges of life. This department organizes for sessions where external speakers come to speak to the students concerning various topics. However, issues on SRH are usually not considered a priority among the list of topics.
b) Friends and peers: While AGYW cited getting information through friends and peers, this source may also contribute to misinformation hence presenting a double edged sword scenario.
c) Social media, local radio stations such as Mikayi FM in Siaya which has a program on "Mine Nyalo" (Women are Able) that talks about family issues.
d) Community Health Promoters (CHPs) through the Community Health Units (CHUs), community action days and households for which they are responsible.

As to the existing platforms or avenues that provide opportunities for AGYW to discuss SRHR matters, the following key platforms and avenues were identified:

a) *Safe spaces within the community level*- These are youth friendly spaces which offers community programs where young people are educated. These are also placing where Community Based organizations (CBOs) and other NGOs are trying to engage young people to know their sexual reproductive rights to empower them with information.
b) *Youth conference*- Where they are brought together to just talk about themselves as young people and how they are dealing with their own sexuality.

> "*We have ongoing mentorship programmes spearheaded by the county department of gender; targeting adolescents and youth in and out of school." KII_Chair County Assembly Gender Committee_Homabay*

c) *Schools* - Schools provide "school health programs" that occasionally hold discussions on sexual and reproductive health and rights (SRHR) issues. Additionally, there are various clubs within schools that address these topics. However, there is lack of quality integrated SRHR education allowed in schools. As a teacher in Homabay pointed out:

> *"I think these are things that should be taught to young people so that they understand their sexuality and know when their rights are infringed." KII Teacher, Homabay*

d) *Other sources*: These include toll-free hotlines, health facility-based discussions, and partner-driven initiatives, all of which provide opportunities for AGYW to discuss SRHR matters.

In Kajiado and Migori counties, there are platforms such as budget participation and social media, but clear channels for communication are lacking. Public forums, such as community gatherings, might address some topics but are often limited by cultural norms such as those concerning Female Genital Mutilation (FGM), early marriages and gender-based violence. In Migori county among the Kuria community where, for example, the FGM practice is embedded in the tradition and cultural norms, the practice may not be publicly voiced or addressed. In addition, the fact that uncut women are normally ostracized and not allowed to take leadership positions, often limits or discourages AGYW from voicing out their concerns. This requires innovative strategies for engaging AGYW where their participation may be hindered by the prevailing cultural norms and practices.

4.2.5 SRHR programs/services in the community geared to supporting AGYW

Across the four study counties, namely Siaya, Kajiado, Homabay and Migori, there were a few SRHR programs/services targeting AGYW. The available programs are implemented by *NGOs that mostly* support information on family planning, comprehensive sexuality education, community outreach and dialogue forums on SRHR topics. Specifically, some of the existing programs targeting AGYW include:

- *Power to Youth Program*- Implemented by AMREF through SIMUN targeting young girls in school and out of schools educating them on their sexuality, giving them information

on sexual education and their rights. This space also provides economic empowerment giving young people economic ideas. "She decides"- by SIMUN which tries to give AGYW safe spaces to meet and discuss SRHR needs that they have.

- A mentorship program by Mildmay targeting young people between 19-24yrs which provides SRHR information.
- Center for Study of Adolescences (CSA) implements the SRHR program under "SHESOARS" targeting the AGYWs.
- Stawisha Africa which started a program of empowering young girls aged 10-24 years, where they are brought together and taught in a village set up.
- Youth care program by NAYA Kenya
- DESIP program (implemented by Population Service Kenya) & Target Group: This program targets AGYW with comprehensive information on family planning.
- Smart heart program supported by KMET that economically supports AGYW and offers care and nurturing support to teen mothers
- Chatbot program by Zana Africa that allows young people to make inquiries on SRHR and report any form of abuse/violence
- Mentorship programs spearheaded by the county department of gender under the Migori County Government, targeting adolescents and youth in and out of school.
- School Health programs on age-appropriate comprehensive sexuality education, implemented in Homabay County in collaboration between by World Vision and school health coordinators, County public health department.

> *"The county clinician coordinates Adolescent and Youth Sexual and Reproductive Health Rights (AYSRHR) activities within the county; cascading down to the sub-counties; we have school health programmes on age appropriate comprehensive sexuality education which is done in collaboration with school health coordinators from the public health department; though it at times results to conflict with the teachers in school." KII, Homabay*

In their assessment, the respondents across the four counties felt that the existing programs and services are highly inadequate and fraught with several challenges to effectively address the SRHR needs of AGYW. The inadequacy of current programs and services was attributed to several factors including limited scope and focus on specific needs. Programs that come into the community targeting young people often have specific focus even though SRH service package is wide-ranging. It was pointed out that most SRHR programs targeting young people tend to only address specific issues like behavior change and Menstrual Hygiene Management. The sustainability question also remains with most SRHR programs in the community being largely donor dependent.

Some of the key gaps and challenges identified in the implementation of the SRHR programs included:

a) Limited resources on the proper implementation of these programs to the grassroots level. This hinders program implementation and outreach which restrict the scope and quality of services offered.
b) Lack of consistency in SRHR program and service delivery.
c) Limited reach: Programs may not cater to all AGYW in the community, especially those in rural areas.

d) Lack of collaboration between partners to maximize impact (KII - Director Gender, Homabay).
e) Overdependence on partner support. As stated by SRHR Advocates in Homabay during a focus group discussion:

> "*There is dependence on partner driven support hence the programs are unsustainable." FGD, Homabay*

f) Lack of youth-friendly services: facilities might be perceived as unfriendly or judgmental.
g) Limited Capacity: inadequate training for healthcare providers and youth leaders on SRHR issues.
h) Some programs are targeting the problem but not the root causes which may be deeply rooted in the traditions and cultural norms and the political economy of the health system.

To address the program gaps and challenges, the respondents proposed several actions including:

a) Increase Investments: County governments should demonstrate more commitment by allocating more funds specific to SRHR targeting AGYW. As stressed by a key informant in Homabay:

> *"Both county and national governments should invest more on SRHR programs for sustainability." KII, Homabay*

b) Mobilize youth from the villages and enable them access the right information. This could be done by proper programming to tackle youth behavior change issues by targeting reproductive health issues.
c) Organize sensitization campaigns and awareness creation forums to inform AGYW about their rights and the importance of SRHR and available platforms.
d) Promote transformative and integrated approaches to SRHR advocacy including strategies for male inclusion in SHRH programming.

e) Train and build the capacity of healthcare providers, youth leaders, and community health promoters on SRHR.
f) Enhance partnerships with schools about sexual reproductive health targeting adolescents.
g) Engage the young people to create community resource centers/community youth-friendly centers in partnership with County departments to bring the services closer to the AGYW.
h) Need to develop a policy framework and legislation that prioritizes adolescent and young people's reproductive health in planning and allocation of adequate resources for SRHR targeting AGYW.
i) Improve access to comprehensive SRHR information, services, and advocacy for AGYW
j) To empower AGYW to make informed choices about their sexual and reproductive health.
k) Ensure youth representation in decision-making processes related to SRHR policies and programs. As a key informant from the National Gender and Equality Commission (NGEC) pointed out:

"there is a concern regarding the leadership of discussions on SRHR, as adolescent spaces are predominantly occupied by adults who tell the young people what to say." KII, NGEC

l) Support economic empowerment and income-generating activities for AGYW to increase their agency and access to resources.
m) Utilize multiple communication channels including radio, social media, and peer education to disseminate SRHR information.

In addition to improving access to SRHR services by the AGYW, the respondents across the counties recommended the need to:

a) Implement comprehensive sexuality education in schools
b) Establish youth-friendly health clinics with trained staff and confidential services
c) Utilize social media and youth-friendly platforms for SRHR information dissemination
d) Engage community leaders and parents to address stigma surrounding SRHR
e) Adopt a multi-sectoral SRHR implementation approach involving education, health, and other relevant sectors. As a key informant from the Gender Sector Working Group stressed:

"enhance engagement with the private sector by developing clear business cases to support SRHR. For example, design budget-friendly sanitary towels to be purchased at subsidized prizes." KII, Gender Sector Working Group

f) Address emerging issues such as drug abuse and unsafe abortions among adolescents
g) Focus on economic empowerment for AGYW alongside SRHR initiatives.

4.3 AGYW participation and inclusion in policy and decision-making

The SRHR advocates from Siaya and Homabay counties during their focus group discussions held the view that AGYW have been involved in varying degrees in policy and decision-making processes relating to SRHR albeit not meaningfully. For instance, in Homabay county the SRHR advocates in their focus group discussion reported that while AGYW participated in the formulation of the Homabay county SGBV policy and Youth Internship Policy 2019, their participation appeared to be more 'ceremonial' than meaningful.

"Their participation was only to make "technical appearance" and to convince partners that indeed AGYW participated, yet their voices were not heard or considered in the entire process." FGD, Homabay.

In Siaya County the AGYW participated in the policy formulation HIV and STIs policy which NASCOP was supporting. The youth also participated in the development of the National Youth Policy. However, for Kajiado and Migori, the respondents didn`t mention specific cases of AGYW participation in policy and decision making rather than being involved in the activities of organized groups.

The respondents therefore identified the need to create friendly spaces and platforms that offer opportunities for young people to express their aspirations and engage duty bearers in

policy formulation and follow up. In Siaya county, an example was given where the Power to Youth programme has established enabling platforms such as youth *barazas* (public meetings/forums) and youth cafes which offer opportunities for the young people to discuss their affairs and to get information and ideas on how to engage duty bearers in policy formulation and implementation. This has increased the participation and engagement of people with leaders and policy makers and in demanding accountability from the government in various sectors in the county.

To improve the AGYW's participation and inclusion in policy and decision-making activities/ processes at various levels, the respondents advocated for a more structured and intentional mobilization of AGYW to attend public participation forums especially on issues of budget, so that they are able to provide their views and even submit memoranda in terms of their priority needs The respondents further emphasized the need for an inclusive environment for AGYW participation including safe spaces for AGYW and youth to express their views; mentorship and support for young advocates; and funding for youth-led advocacy initiatives.

4.4 SRHR Policy Implementation Gaps and Effect on the AGYW

When asked whether they were aware or knew of any policies that address sexual reproductive health and rights, most of the respondents including youth advocates, community health workers and representatives, county reproductive health leaders and teachers/education officials recognized the existence of various policies and legislation that address SRHR matters at both national and county levels. The various policies and legislation reported at the national level are described under Annex 1 of the literature review. At the county level, except for Kajiado county, the respondents identified Migori County Gender Based Violence (GBV) Policy (2020); Homabay County SGBV Policy; and Siaya County Youth Policy in 2016. No SRHR related policies or laws were reported in Kajiado County.

Asked about the benefits and effects of the implementation of the SRHR policies on the adolescent girls and young women, the respondents across the board recognized that existing SRHR policies provide the necessary guidance for addressing SRHR issues and the enabling framework for the young people to claim and enjoy their SRH rights and to participate in decision making. It was pointed out that the SRHR policies and the constitutional framework guarantee access to reproductive healthcare for all including the AGYW. Specifically, the respondents identified a number of other benefits and effects of the existing SRHR policies on the adolescents and young people. Some of the benefits and positive effects mentioned included:

a) Empowerment with knowledge and confidence to make informed choices about their sexual and reproductive health.
b) Reduced school dropout rates due to unintended pregnancies or menstrual hygiene challenges. Enhanced access and return to school even for the young women after delivery.
c) Clear direction on what both national and county governments must do to achieve universal health coverage including reproductive care coverage.
d) Improved health outcomes for AGYW including reduced teenage pregnancies, safer childbirth practices, decreased risk of sexually transmitted infections (STIs)/HIV and improved quality of life.

e) Increased participation of young people in decision making through various Gives an effective platform: AGYW have a manual that would help a lot and make it easy to handle sexual reproduction issues.
f) Increased awareness of SRHR thereby enabling young people to make informed choices and contributing to dispelling myths and misconceptions about SRH.
g) Increased availability and access to youth-friendly healthcare facilities and SRH services including essential RH commodities.
h) Reduced harmful practices like FGM thereby promoting AGYW's well-being.

On the flipside, some of the respondents especially from Migori and Kajiado counties held the view that young people especially AGYW with access to SRHR programs normally experience backlash and ostracisation in the communities especially those that still beholden harmful cultural norms and practices. It was further pointed out that the existing policies have not adequately addressed the use of local alternative dispute resolution (ADR) systems that hinder access to justice by survivors of SGBV and FGM. In addition, the respondents expressed concern over their poor implementation and enforcement record. The poor record of policy implementation was largely attributed to inadequate exchequer budget allocation for SRHR programs and services, dependence on donors and limited awareness of the existing policies and opportunities they provide. For example, in Migori county, the County Assembly Gender Representatives Officer mentioned that young people are not well informed and hence a program is required for them to get engaged.

To address the challenges of poor policy implementation, the respondents proposed the need to advocate for increased budget allocations for SHRH programmes and to sensitize members of county assemblies on their obligation to provide adequate appropriation for SRHR services and public participation in line with the Constitution of Kenya. As a key informant from Siaya County emphasized, *"we need to walk the talk, and act because if action is not taken then there is nothing we are doing."*

4.5 Assessment of social accountability in the implementation of SRHR policies

Asked about whether they were aware of any mechanism(s) and tools used for holding leaders/duty bearers accountable in the implementation of the SRHR policies, youth/SRHR advocates identified a number social accountability mechanisms used across the counties. Kajiado reported using budget analysis, petitions and memoranda tools. Siaya reported using community scorecard, citizen charter, public revenue hearing and public expenditure tracking mechanisms and tools. Siaya county also reporting engaging with the Governor's RoundTable (GRT), Governor's Delivery Unit, and Budget and Economic Forum. Homabay reported the use of scorecard and social audits while Migori county reported using budget analysis, social audits and public hearings, memorandums, petitions and position papers tools.

4.5.1 Participation in social accountability processes

AGYW through the focus group discussions were specifically asked whether they participated in any social accountability activities and which activities they were involved in and their experiences. The study found that AGYW participation levels in social accountability activities varied across the four counties. Siaya like Migori County reported some positive examples of young people including AGYW's engagement with the social accountability mechanisms including their participation in public forums, involvement in scorecard assessments and writing letters and petitions. The motivation of the AGYW to participate in social

accountability processes stemmed from increased awareness of their rights, personal experiences and desire to voice their concerns about inadequate access to quality SRHR services. Other counties, namely Kajiado, and Homabay generally reported limited AGYW participation, with respondents attributing this to a lack of adequate knowledge about social accountability processes.

When asked about what enabled or inhibited AGYW's involvement in the social accountability activities, the AGYW reported a number of key enablers including support from SRHR organizations and youth alliances; creation of awareness about existing mechanisms; SRHR education to empower AGYW with knowledge and confidence; mentorship and support from experienced advocates; and use of youth-friendly communication channels like social media. On the other hand, some inhibiting factors for effective participation in social accountability processes included lack of knowledge about rights and advocacy processes; difficulties in accessing leaders/policymakers; and socio-cultural barriers that discourage AGYW from speaking out.

Generally, the AGYW respondents across the four counties indicated that the existing social accountability spaces and platforms such as public participation forums were not very AGYW-friendly due to the prevailing cultural norms and stigma around SRHR issues, limited access to information on SRHR policies, and lack of follow-up and feedback mechanisms. The respondents emphasized the need to create safe spaces for young people to effectively engage and dialogue with leaders and policymakers on matters that affect them. The AGYW in Migori proposed the need to identify and equip safe spaces within the CSO spaces like Tunaweza Empowerment organization in Migori county. In Siaya, the SHRH advocates felt the need to have community integrated forums where AGYW and policy makers are brought together to have discussions, get the views of the AGYW, voices and recommendations on what works for them. In addition, they stated the need to strengthen SRHR community academies within the counties where AGYW would be brought together to form groups, access information and undergo targeted mentorship on SRHR to be become SRHR champions.

AGYW and SRHR advocates also identified the need to expand SRHR outreach programs as well as the use of multimedia communication strategies to reach young people especially AGYW. The AGYW felt that the use of multimedia strategies such as social media and mass media including vernacular FM stations is crucial in terms of ensuring wide coverage of young people in varying contexts, for example, during dissemination of information and public education campaigns and in diverse community and institutional settings.

Overall, it was however observed that the facilitation of young people including AGYW's participation in policy implementation and decision making processes was inconsistent across counties, with most participation reported where there was support from youth alliances and NGOs. In addition, there was limited evidence of feedback on actions taken by officials, even though Siaya reported some improvements in local dispensaries following scorecard assessments.

4.5.2 Assessment of effectiveness of Social Accountability Approaches and Tools

Social accountability the use of a broad range of tools that citizens, communities, independent media and civil society organizations to hold public officials and public servants accountable and to trigger change.[51] These include community scorecard, social audits, citizen scorecard, gender budgeting, public expenditure tracking, public hearings, participatory planning and budgeting, audio-visual documentation of rights violations, monitoring of public service delivery, investigative journalism, public commissions, whistle blowing, and citizen charters among others.

Asked to identify any best practices in the use of social accountability tools in the implementation of SRHR policies, some examples of best practices were reported from Siaya and Homabay counties. In Siaya county, examples of best practices included the utilization of multiple advocacy tools such as petitions, social media campaigns, community dialogues; young people partnering with experienced NGOs and youth groups to facilitate and demand for social accountability; focus on clear and achievable demands for policy improvement; and conducting scorecard assessments. In Homabay County, young people who were part of the Homabay Youth Parliament participated in social accountability advocacy activities, supported by "Power to Youth" to conduct a community scorecard at Kandiage Health Center. As a result of the community scorecard, it was reported that the facility established a youth friendly corner/offering youth friendly services and that additional staff (3) were recruited, contributing to efficient service delivery.

Asked to assess the effectiveness of the existing social accountability approaches and tools used, most of the respondents across the board and counties held the view that the use of the existing approaches and tools is limited in terms of reach. This they attributed to few CSOs working with young people in the social accountability spaces; lack of follow-up and feedback mechanisms on issues raised and actions proposed during participation; and insufficient youth-friendly spaces to ensure effective and unhindered engagement by young people.

Overall the key lessons learnt from AGYW participation in social accountability interventions in policy implementation was the need for better coordination among social accountability seekers and the importance of access to information, follow up and feedback in the social accountability processes.

4.6 Capacity to advocate for policy change and hold decision-makers accountable for policy implementation

Across all the counties, there was a consensus that AGYW and youth SRHR advocates generally lacked the necessary capacity to effectively advocate for policy change and hold decision-makers accountable. This was due to limited workshops and trainings offered by NGOs or government agencies, inadequate funding and resources for capacity building and training; lack of mentorship programs and opportunities with experienced advocates; lack of access to online resources on SRHR advocacy and social accountability; and inadequate

[51] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

networking opportunities. Common capacity needs and gaps identified across the counties included:

a) Knowledge and training on SRHR issues, rights, and policies, advocacy skills and understanding of social accountability mechanisms,
b) Resources for mobilization and advocacy activities
c) Networking and engagement opportunities with decision-makers
d) Safe spaces for open discussions on SRHR issues.

Generally, *access to* social accountability and advocacy training varied across the four counties. Siaya reported more specific examples, including training on budget formation processes and social accountability. Overall, there was limited participation in formal social accountability and advocacy training across the counties, highlighting a potential capacity gap. Where training occurred, it was generally viewed positively. In Siaya county for example, respondents noted that the training created significant change, even though time constraint was a major limitation. To improve social accountability and advocacy training offerings across the four counties, the respondents made some recommendations including the following:

a) Increasing public investment in comprehensive training on SRHR issues, advocacy skills, and social accountability mechanisms
b) Creating more awareness in the community about social accountability and targeting village-level leaders (chiefs, village elders) and persons with disabilities in training,
c) Making training sessions more comprehensive and longer
d) Ensuring training is interactive, culturally sensitive, and delivered in an adolescent and youth-friendly way
e) Facilitating mentorship programs connecting young advocates with experienced mentors and providing follow-up support and mentorship after training
f) Providing funding and resources for youth-led advocacy initiatives
g) Creating platforms for networking and collaboration among young advocates,
h) Fostering safe spaces for open discussions on SRHR issues
i) Increasing involvement of AGYW in decision-making processes, and enhancing community awareness and support for AGYW SRHR advocacy

4.7 Discussion

The study findings underscore that young people, including adolescent girls and young women (AGYW), have a considerable understanding of the sexual and reproductive health rights (SRHR) challenges within their communities. This awareness reflects a significant step towards addressing these issues, as informed community members are more likely to engage in advocacy and accountability processes. The assessment of social accountability mechanisms, such as citizen scorecards, social audits, and public hearings, revealed varying levels of effectiveness. While these tools have potential, their real-world impact is often inconsistent. Factors contributing to this variability include differing levels of community engagement, government responsiveness, and the capacity of young people and AGYW to utilize these tools effectively.

The study highlighted that while there is a significant awareness of SRHR issues, actual engagement and participation in social accountability processes are hindered by several barriers including:

a) Cultural norms, taboos and stigma: Cultural norms and societal taboos surrounding SRHR continue to pose significant barriers. These social dynamics can discourage open discussion and hinder meaningful participation, particularly for adolescent girls and young women.
b) Lack of awareness and capacity: There is a clear need for comprehensive capacity-building programs. Many adolescent girls and young people lack the necessary knowledge and skills to advocate effectively and engage with existing social accountability mechanisms.
c) Power dynamics: In some cases, power imbalances within communities prevent marginalized groups from having their voices heard in social accountability processes. This leads to identified priorities that may not reflect the actual needs of the most affected individuals.

The study also revealed substantial gaps in the knowledge and competencies/capabilities needed for effective advocacy and use of social accountability tools among young people including AGYW. Addressing these gaps through targeted education and training would empower young people and AGYW to lead SRHR initiatives more effectively. The findings emphasize the need for inclusive approaches that embrace the diverse voices within the community, particularly those of vulnerable and marginalized groups including young people and AGYW. Equitable engagement strategies are crucial for ensuring that all affected individuals can participate in social accountability processes. This inclusive approach is vital for identifying and addressing the true SRHR priorities and needs of the young people and community.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Young people including AGYW across the four counties demonstrated clear understanding of the existing sexual and reproductive health and rights (SRHR) challenges within their communities. They understood that sexual and reproductive health and rights are critical entitlements that are supported by a broad range of social accountability mechanisms and tools that enable and empower citizens and communities to hold duty bearers accountable. Social accountability was thus appreciated as a key strategy to enabling young people enjoy and realize their sexual and reproductive health and rights. Some of the social accountability tools that have been used with varying degrees of success to address sexual and reproductive health and rights issues included citizen/community scorecard, petitions, social audits, public hearings, participatory planning and budgeting and citizen charters.

Despite the existence of a broadly enabling policy and legal environment and a range of social accountability mechanisms to support young people 's engagement in decision making, in practice, they reported having limited opportunities for meaningful engagement with decision makers. Most respondents across the board held the view that the use of social accountability mechanisms and tools in the SRHR space was inadequate. They attributed this to, among other things, few CSOs working in the social accountability spaces, lack of information, awareness and knowledge, lack of follow-up and feedback mechanisms, and insufficient youth-friendly platforms. Other key factors affecting young people's participation and utilization of available social accountability mechanisms and tools included limited scope and focus of many existing SRH programs and negative gender, social and cultural norms leading to their perceived exclusion from governance and decision making spaces.

Furthermore, AGYW and SRHR advocates expressed inadequate or lack of capacity among AGYW and young people to effectively advocate for policy change and hold decision-makers accountable. This was attributed to limited training and capacity building opportunities, inadequate funding for capacity building, and lack of mentorship programs and opportunities with experienced advocates. The key lessons learnt from AGYW participation in decision making and social accountability processes included the need for intentional creation of youth friendly platforms, access to information, training and capacity building opportunities and follow up and feedback mechanisms for young people.

Overall, getting young people to the centre of governance and social accountability with respect to their SRHR needs and priorities requires demonstrated political will and commitment at all levels. This is imperative for strengthening social accountability mechanisms and building young people's capacity to claim their rights and effectively engage with, and hold duty bearers accountable for their decisions and actions, and to advocate for policy change.

5.2 Recommendations

From the foregoing, the following recommendations are made:

1. Education and awareness

a) Develop comprehensive education and awareness program targeting AGYW and young people to facilitate their meaningful participation in SRHR decision making and social accountability
b) Promote a multi-sectoral approach to SRHR for young people and AGYW
c) Strengthen social accountability mechanisms including feedback and follow-up mechanisms for young people.
d) Utilize media advocacy tools, including social media, to raise awareness and hold leaders accountable.
e) Enhance civic education from the village level to the national level.

2. Building capacity in social accountability and advocacy

a) Government departments and agencies in partnership with CSOs to establish and explore opportunities for training and capacity building of young people and AGYW to meaningfully engage in decision making, social accountability and advocacy.
b) Develop comprehensive multi-level training curriculum and mentorship program for SRHR advocates and champions adaptable to AGYW platforms and spaces of engagement.
c) County governments to include SRHR mentorship programs in youth programs, plans and budgets.
d) Build capacity of government/decision makers including elected leaders on SRHR issues, social accountability and youth participation and engagement.

3. Promoting AGYW participation in social accountability and decision-making processes

a) Fully operationalize existing frameworks, mechanisms and youth friendly spaces for engaging young people and AGYW
b) Strengthen local social accountability mechanisms and digital and social media spaces to raise awareness and hold leaders accountable.
c) Enhance young people and AGYW's access to decentralized participation forums and online platforms

4. Building enabling policy, legislative and financing environment

a) Strengthen policy and legislative environment framework youth participation and engagement in decision making and social accountability at all levels.
b) Advocate for increased youth representation and AGYW participation in decision makings spaces at community, county and national level.
c) Build enabling social and cultural environment at the community level to address restrictive gender, social and cultural norms that limit AGYW and young people's participation in governance, decision making and social accountability mechanisms.
d) Strengthen social accountability mechanisms including feedback and follow-up mechanisms for young people

e) Advocate for increased budget allocation for public participation and social accountability activities for young people and AGYW in governance and decision making.

5. Promoting evidence-based decision making and advocacy

a) PtY and CSO to partner to review the existing social accountability mechanisms and approaches and their effectiveness.
b) PtY and CSO to enhance dissemination and sharing of SRHR social accountability research findings, reports and related knowledge products through TWG and grassroots CSOs networks
c) PtY and CSOs to partner in to develop and implement an innovative behavior change strategy and program to address prevailing negative gender, social and cultural norms and practices
d) Enhance and make the voices of the vulnerable and marginalized including young people and AGYW to ensure inclusion in governance, decision making, social accountability and advocacy processes at all levels.

6. Further research

Based on the findings several areas warrant further research to enhance our understanding of effectiveness social accountability approaches and practices in addressing the implementation gaps in sexual and reproductive health rights (SRHR) policies.

a) Investigate best practices and case studies on effective social accountability mechanisms at community, county, and national levels to develop a comprehensive framework for the use social accountability in SRHR.
b) Examine the influence of cultural values, social norms, and societal judgments regarding sexuality, single motherhood, and fertility on the engagement and participation of young people, particularly girls and young women, in social accountability initiatives.
c) Conduct detailed assessments of the effectiveness of various tools such as citizen scorecards, social audits, and public hearings. Identify which tools are most effective in different contexts and conditions and how they can be optimized for broader application.
d) Explore the most effective strategies for strengthening the capacities of young people, especially AGYW, to engage in social accountability processes. This includes training, mentorship, and support systems that can empower young people and AGYW.
e) Investigate the mechanisms through which feedback from community-level social accountability actions is communicated back to the community and how this feedback loop can be strengthened to ensure transparency and trust in the process.

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ANNEX 1: LITERATURE REVIEW

1. Introduction

Comprehensive literature review was one of the key strategies adopted to gain a comprehensive understanding of social accountability approaches and tools in the implementation of Sexual and Reproductive Health and Rights (SRHR) policies. Literature review entailed an in-depth review and analysis of existing evidence on the sexual and reproductive health situation, legal and policy environment for SRHR and factors and dynamics of social accountability in adolescent and young women's SRHR.

2. Why sexual and reproductive health and rights (SHRH) for adolescent and young women matter

Article 43 (1) (a) of the Constitution of Kenya guarantees the right of every person to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 14 of the Maputo Protocol also guarantees the respect and promotion of women's right to health, including sexual and reproductive health (SRH). The Sustainable Development Goal (SDG) 3.7 aims to ensure universal access to sexual and reproductive health-care services, including family planning, information and education, as well as the integration of reproductive health into national strategies and programmes. SDG 5.6 on gender equality further calls for ensuring universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

3. Definition and classification of adolescents and young people

Broadly, the terms children, adolescents, youth and young people vary widely depending on the context and the source of information including a particular country's laws and culture. Although there is no universally accepted definition of "adolescents", it is broadly defined as the period from 10 years to 19 years of age.[52] "Young people" on the other hand, comprise people in the age range of 10 to 24 years. World Health Organization classifies adolescents as children aged 10-19 years and those aged 20-24 years as young people.

The Constitution of Kenya 2010 defines "youth" as the collectivity of all individuals who have attained the age of 18 years, but have not attained the age of thirty-five years. The Kenya Constitution 2010 also defines a child as an individual who has not attained the age of 18 years and an adult as an individual who has attained the age of eighteen years. There is further classification of women of childbearing years, a cohort that is the target of Demographic Health Surveys which groups, adolescent girl, young women and older women as one cohort aged 15 to 49 years.

The United Nations Convention on the Rights of the Child (CRC) encompasses all individuals from birth to 18 years in the category of children. A significant proportion of adolescents and young people are covered under the protection of the CRC until they reach 18 years of age.

[52] UNFPA and Save the Children USA, Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, September 2009

Depending on the context and the type and source of information, adolescents can therefore be construed in certain circumstances as children requiring parental consent in service provision or in certain critical decisions when age consent has not been attained. Table 4 below summarizes international definitions of children, adolescents, youth and young people.

Table 4: International and constitutional definitions of children, adolescents, young people and youth

Term	Age Range	Source
Children	0-18 years	Convention on the Rights of the Child; Constitution of Kenya
Adolescent	10-19 years	UNFPA, WHO, UNICEF
Very young adolescent	10-14 years	UNFPA, UNICEF
Youth	15-24 years	UNFPA, WHO, UNICEF
	18-35 years	Constitution of Kenya
Young people	10-24 years	UNFPA, WHO, UNICEF

By 2020, over 12.7 million Kenyans were adolescents ages 10-19 years accounting for nearly one-quarter (23.7 percent) of Kenya's population.[53] Certain sub-groups of adolescent girls and young women, including those who are very young, pregnant, or marginalized are considered to be at high-risk. Other adolescent girls and young women fall into high-risk subgroups as a result of conflicts, disaster and emergency situations. The adolescent sub-groups that are at risk by definition include the following:

a) **Very young adolescents (10-14 years),** especially girls**,** are at risk of sexual exploitation and abuse (SEA) because of their dependence, lack of power, and their lack of participation in decision making processes. Because of their limited life experience, they may not recognize the sexual nature of abusive or exploitative actions.
b) **Pregnant adolescent girls,** particularly those under 16, are at increased risk of obstructed labor, a life threatening obstetric emergency that can develop when the immature pelvis is too small to allow the passage of a baby through the birth canal. Delay in treatment can lead to obstetric fistula or uterine rupture, hemorrhage and death of the mother and child. Emergency obstetric care services are often unavailable in especially rural settings and informal urban settlements, increasing the risk of morbidity and mortality among adolescent mothers and their babies.
c) **Marginalized and vulnerable adolescents**, including those who are HIV+ and those with disabilities may face difficulties accessing services because of stigma, prejudice, culture, language and physical or mental limitations. In addition, they are at risk of sexual exploitation and abuse (SEA) because of their lack of power and participation.
d) **Adolescent heads of household** lack the livelihood security and protection afforded by the family structure, which puts them at risk for sexual exploitation and

[53] Statista. Demographics. Available from: https://www.statista.com/statistics/1266462/share-of-adolescentpopulation-in-kenya/

abuse (SEA). Adolescent heads of household may be compelled to drop out of school, marry or "sell sex" in order to meet their needs for food, shelter or protection.

In addition, there are adolescent sub-groups that become at-risk during disaster, emergency or crisis situations. These include:

a) **Adolescents separated from their families (parents or guardians)** lack the livelihood security and protection afforded by the family structure, which puts them at risk for sexual exploitation and abuse (SEA). Separated adolescents may be compelled to drop out of school, marry or "sell sex" in order to meet their needs for food, shelter or protection.
b) **Survivors of sexual violence and other forms of gender-based violence (GBV)** are at risk of unwanted pregnancy, unsafe abortion, STIs including HIV, as well as mental health, psychosocial problems and social stigmatization.
c) **Adolescent girls "selling sex"** are at risk of unwanted pregnancy, unsafe abortion, STIs and HIV. They are at risk of abusing drugs and alcohol and of sexual exploitation and abuse (SEA). For adolescents below age 18, this is considered to be sexual exploitation of children.
d) **Children Associated with Armed Forces and Armed Groups (CAAFAG), both boys and girls,** are often sexually active at a much earlier age and face increased risk of exposure to HIV. Members of armed forces and groups in general, including adolescents, are at high risk of HIV infection given their age range, mobility, and risk-taking attitudes.

4. The situation and challenge of adolescents and young people's SRH

Globally, more than half of the world's population is under 25 years.[54] According to recent UN figures, 1.8 billion adolescents aged 10-19 years old make up more than 16 per cent of the world's population, of whom almost 90% of these adolescents live in low- and middle-income countries (LMICs).[55]

In Sub Saharan Africa, young people between ages 15 and 24 years constitute about 20 percent of the total population.[56] The region is home to over 250 million adolescents aged 10–19 years, or 20 percent of all adolescents globally. This proportion is expected to increase to 24 percent by 2030.[57] This is equally the most educated and energetic lot and hold a lot of promise as far as harnessing demographic dividend is concerned. In Kenya, according to the 2019 Population and Housing Census, Kenya's population of adolescents and young people between 10- 24 years constituted 34% of the population out of a total of 47.5 million,[58] meaning that one in three Kenyans is in the adolescents and young people's age bracket. However, reproductive

[54] Pathfinder, Why We Focus on Adolescent and Youth Sexual and Reproductive Health https://www.pathfinder.org/focus-areas/adolescents-youth/?utm
[55] Un General Assembly (2018) Youth and Human Rights, Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General on 10–28 September 2018 A/HR/39/33
[56] Cornell Research, The Exploding Youth Population in Sub-Saharan Africa, https://research.cornell.edu/research/exploding-youth-population-sub-saharan-africa#
[57] United Nations, Department of Economics and Social Affairs. World population prospects, 2019. https://population.un.org/ wpp/Download/Standard/Interpolated/.
[58] Kenya National Bureau of Statistics (KNBS) 2022, 2019 Kenya Population and Housing Census, Analytical Report on Youth and Adolescents, Volume XII, April 2022.

health issues remain a leading cause of illness and death for women and girls of reproductive age in developing countries.

Despite the fact that sexual and reproductive health and rights (SRHR) is an essential building block to achieving universal health coverage and gender equality, its access is restricted globally. Globally, there are about approximately 4.3 billion people of reproductive age who lack at least one essential sexual or reproductive health service over the course of their reproductive life. In developing countries, more than 200 million women want to avoid pregnancy but aren't using modern contraception, more than 45 million women have inadequate or no antenatal care, and more than 30 million women do not deliver babies in a health facility. In addition, an estimated 80 million women each year have unintended or unwanted pregnancies, and every minute a woman dies from a complication of pregnancy or childbirth.[59]

Consequently, one of the major obstacles to capturing the demographic dividend is the sexual and reproductive health and rights (SRHR) of adolescents and youth in the Sub Saharan Africa, which is characterized by high rates of adolescent pregnancies and a high proportion of unmet family planning needs.[60] In sub-Saharan Africa, two-thirds of illnesses women of reproductive age experience are caused by sexual and reproductive health problems. The leading cause of death for girls 15-19 years is complication in pregnancy and childbirth. 23 million adolescents need contraception, but they don't have it while over 1 billion young people need accurate, unbiased information and healthcare free from judgment.[61]

In Kenya, while some progress has been realized in improving sexual and reproduction health indicators as shown by the KDHS 2022, poor sexual and reproductive health outcomes remain a challenge for many adolescents and young people today. Teen pregnancy and HIV are among the major drivers of morbidity and mortality among adolescents. Adolescent girls in particular are disproportionately affected, often resulting in a lifetime of missed education and life opportunities.

Although Kenya's teenage pregnancy rate has reduced, it has worsened among girls without education. One in every five adolescent girls between 15 and 19 is either pregnant or is already a mother, with over 300,000 girls aged between 10-19 becoming pregnant every year.[62] According to the 2022 KDHS, 15% of women age 15–19 have ever been pregnant; 12% have had a live birth, 1% have had a pregnancy loss, and 3% are currently pregnant. This is a modest 3% decline over the rates in KDHS 2014. The percentage of women age 15–19 who have ever been pregnant increased with age, from 3% among those age 15 years to 31% among those aged 19.[63]

[59] Leah Rodriguez (2021) What Is SRHR? Everything to Know About Sexual and Reproductive Health and Rights, Global Citizens, October 22, 2021. https://www.globalcitizen.org/en/content/sexual-reproductive-health-rights-srhr-explained/

[60] UNFPA (2019) Adolescent and Youth Sexual and Reproductive Health and Rights Services Key elements for implementation and scaling up services in West and Central Africa.

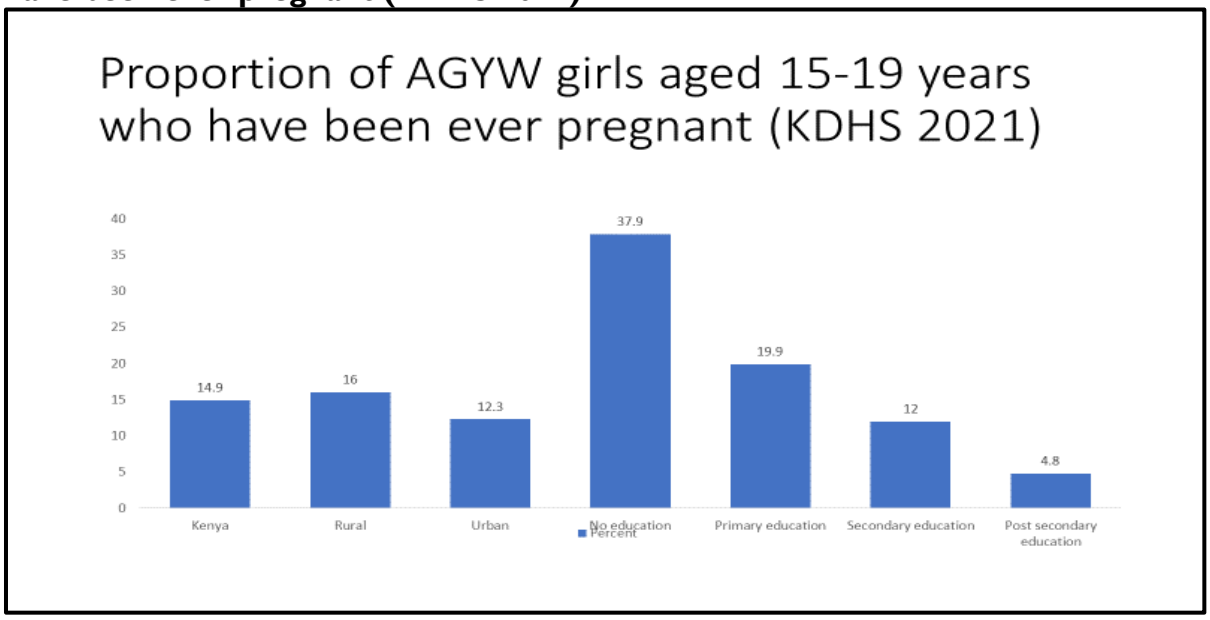
[61] Pathfinder, Why We Focus on Adolescent and Youth Sexual and Reproductive Health https://www.pathfinder.org/focus-areas/adolescents-youth/?utm

[62] UNFPA, Adolescents Sexual and Reproductive Health Development Impact Bond. https://kenya.unfpa.org/en/ASRHDIB

[63] Kenya National Bureau of Statistics (2023), Kenya Demographic and Health Survey 2022, Key Indicators Report, January 2023

About 4 in 10 women age 15–19 who had no education had ever been pregnant, as compared with only 5% of women who had more than secondary education. The gap in the teenage pregnancy rate of adolescent girls with primary education and higher and those without education widened between the 2014 KDHS and the 2022 KDHS. In 2014, about three out of ten (29.2%) adolescent girls aged 15-19 years with no education were pregnant compared to 8.8% among those with more than secondary education while, in 2022, it was three out of ten (30.8%) compared to 4%.[64] While teenage pregnancy has reduced, more needs to be done to support adolescent girls to stay in school to avert many more unwanted and unintended pregnancies.

Figure 4: Proportion of Adolescent girls and young women aged 15-19 years who have been ever pregnant (KDHS 2022)



Source: KDHS 2022

The teenage pregnancy rate was also highest among adolescent girls from the poorest households (those in the lowest wealth quintile) and lowest among adolescent girls from the richest households (those in the highest wealth quintile). The percentage of women who had ever been pregnant decreased from 21% among those in the lowest wealth quintile to 8% among those in the highest wealth quintile.

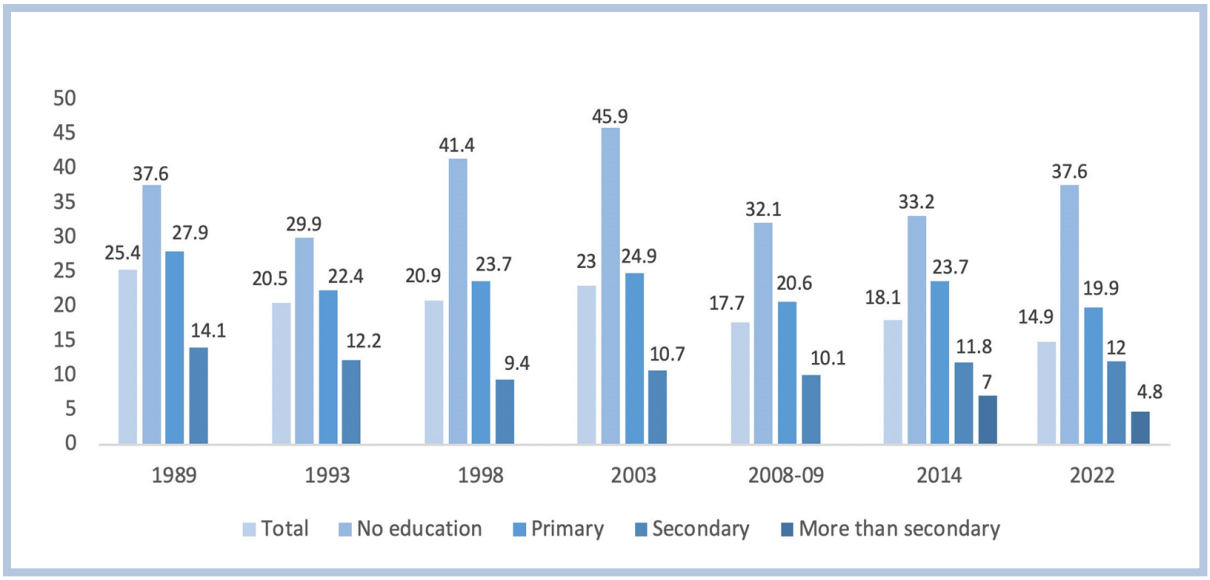
Eighteen (18) out of Kenya's 47 Counties have teenage pregnancy rates higher than the national level including three Counties that have rates of about 20% including over 50% in Samburu, 36.3% in West Pokot, 29.4% in Marsabit, 28.1% in Narok, 24% in Meru, 23% in Homa Bay, 23% in Migor, 22% in Kajiado, 21% in Siaya, and 20% in Baringo. Nyeri and Nyandarua Counties have the lowest teenage pregnancy rates (5% each).[65]

Figure 3 shows that there has been a gradual decline in the teenage pregnancy rate (i.e., girls ages 15-19 years who have begun childbearing) from 25.4% in 1989 to 17.7% in 2008-09 to 14.9% in 2022. Along with the decline in the national teenage pregnancy rate, the number of

[64] African Institute for Policy Development (AFIDEP) (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023
[65] Kenya National Bureau of Statistics (2023) Kenya Demographic and Health Survey 2022 Key Indicators Report, KNBS January 2023

births per 1000 adolescent girls ages 15-19 years was halved between 1989 and 2022, reducing from 153 to 73 in that period.[66]

Figure 5: Girls ages 15-19 years who have begun childbearing (%) by level of education

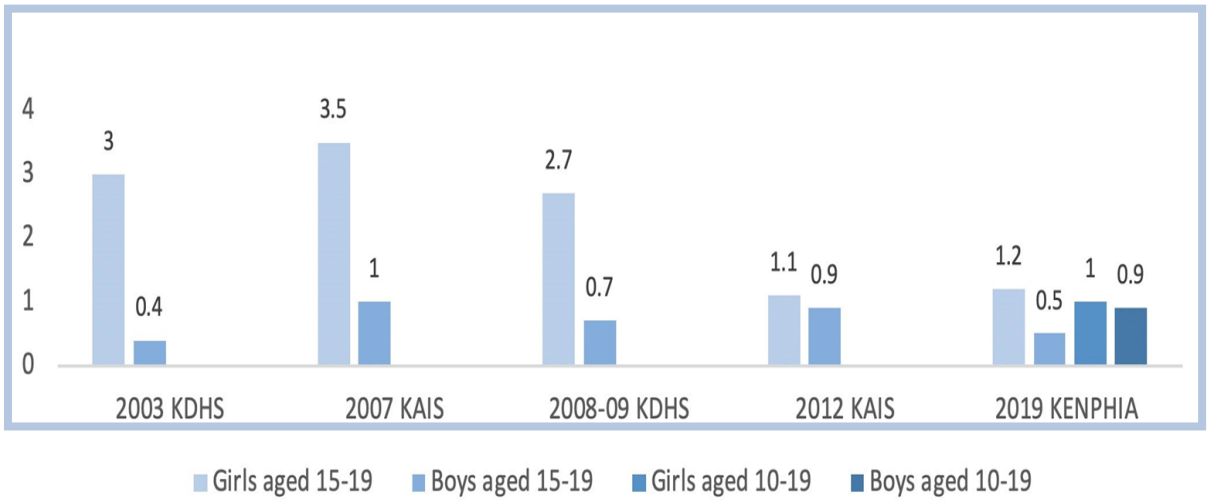


Source: AFIDEP (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023

HIV prevalence among adolescent girls ages 15-19 years has remained consistently higher than their male counterparts (Figure 4). While the HIV prevalence among adolescent girls reduced between 2003 and 2012 from 3% to 1.1%, it stagnated between 2012 and 2018 at 1.1% and 1.2%, respectively.[67] At the age of 15-19 years, 5-7 HIV-infected girls partner with one boy, and the ratio narrows with the increase in age, whereas in the 20-24 years ratio is 2:1. In Kenya, 42% of all adult new HIV infections occur among adolescents and young people aged 15-24.[68] Among women, the percentage who reported using a condom at last sex with a person who neither was their spouse nor lived with them decreased with age, from 46% among women age 15–19 to 29% among women age 30–49.[69]

[66] African Institute for Policy Development (AFIDEP) (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023
[67] African Institute for Policy Development (AFIDEP) (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023
[68] 2019 Kenya Population Based HIV Impact Assessment (KENPHIA)
[69] Kenya National Bureau of Statistics (2023) Kenya Demographic and Health Survey 2022 Key Indicators Report, KNBS January 2023

Figure 6: Figure 6: HIV prevalence among adolescent girls and boys (%)



Source: AFIDEP (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023

Slightly more than half of young women of age 15-24 (54%) in Kenya know about HIV prevention. Knowledge of prevention is lowest among respondents age 15–17 (44% each of women) and among those who have never had sex (47% of women). Young women in urban areas are more likely than their counterparts in rural areas to have knowledge about HIV prevention; 57% of young women in urban areas have knowledge about prevention, as compared with 52% of young women in rural areas. Knowledge about HIV prevention increases with increasing education, from 13% among young women with no education to 69% among those with more than a secondary education.[70]

STIs are also a significant health concern for adolescents due to their long-term reproductive health consequences related to fertility, pregnancy and foetal outcomes and cervical cancer. The trend in self-reported sexually transmitted illnesses (STI) and symptoms mirrors that of the HIV prevalence. A larger proportion of adolescent girls ages 15-19 years report an STI, genital discharge, or a sore or ulcer compared to their male counterparts.

Rural, poor and uneducated adolescent girls are at highest risk of early marriage. Education has a strong positive effect on women's median age at first marriage. In 2014, the median age at first marriage among women ages 25-49 years was 17.9 years among those with no education, 19 years among those with primary education, 21.5 years among those with secondary education and 24.9 years among those with more than secondary education. The median age at first marriage is also influenced by where adolescents live and their income status. In 2014, twenty (20) counties recorded a median age at first marriage among women ages 25-49 years that was higher than the national level (i.e., 20 years and over). The median age at first marriage was lowest in Migori (17.1), Tana River (17.3), Homa Bay (17.5), Wajir (18.1), and Marsabit (18.3).[71]

[70]Kenya National Bureau of Statistics (2023), Kenya Demographic and Health Survey 2022, Key Indicators Report, January 2023

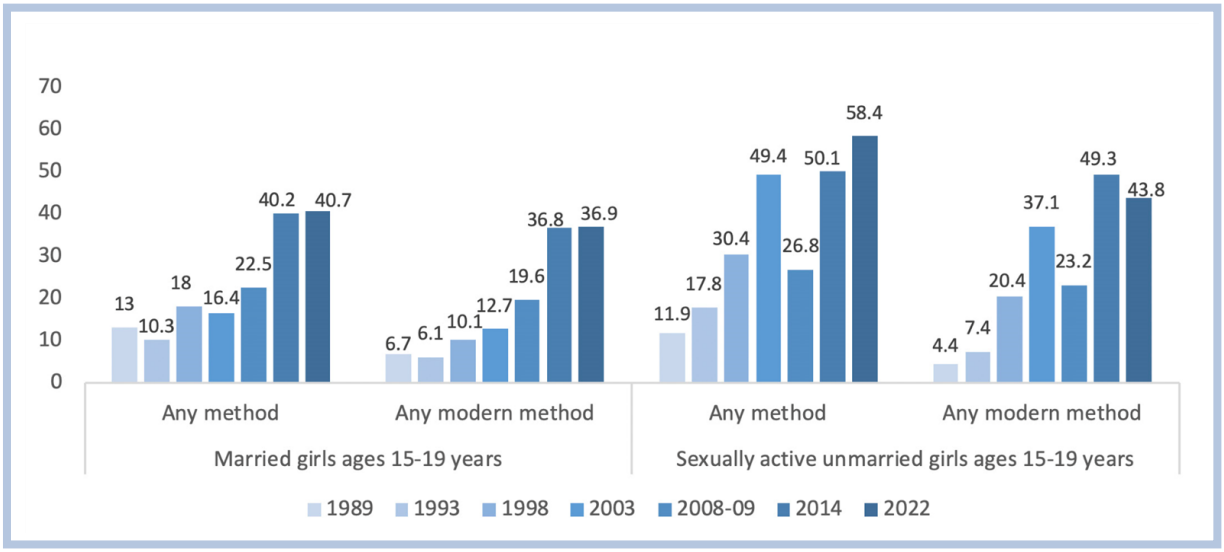
[71] African Institute for Policy Development (AFIDEP) (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023

Use of contraceptives, particularly modern contraceptives, among married and unmarried sexually active adolescent girls ages 15-19 years has increased considerably between 1989 and 2022 as shown in Figure 5. Among the modern contraceptives used by adolescent girls, use of condoms, which is the best way to prevent the spread of STIs (including HIV) has also increased over this period among sexually active unmarried adolescent girls but remains low, and stagnated at 27.3% between 2014 and 2022.

Condom use is uncommon among married adolescent girls and increased less rapidly compared to their unmarried counterparts between 1989 and 2022 from 0% to 3.7%. In addition, sexually active adolescent girls with more than one partner are less likely to use a condom compared to their male counterparts. In the 2022 KDHS, 1.5% of adolescent girls ages 15-19 years compared to 5.3% of adolescent boys ages 15-19 years reported having two or more partners. Among them, 30.7% (less than a third) of the adolescent girls and 63.5% (nearly two-thirds) of the adolescent boys reported using a condom during their last sexual intercourse.

Notably, between 2014 and 2022, use of traditional contraceptive methods increased considerably among sexually active unmarried adolescent girls from 0.7% to 14.6%. Despite an increase in use of contraceptives by married and unmarried sexually active adolescents, unmet need for contraceptives (particularly modern contraceptives) remains high compared to older cohorts of women. In 2022, 21.6% of married adolescent girls and a third (34.5%) of sexually active unmarried adolescent girls had an unmet need for contraceptives compared to the national level of 14% among women ages 15-49 years.[72]

Figure 7: Current use of contraceptives among adolescent girls ages 15-19 (%)
Source: African Institute for Policy Development (AFIDEP) (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023



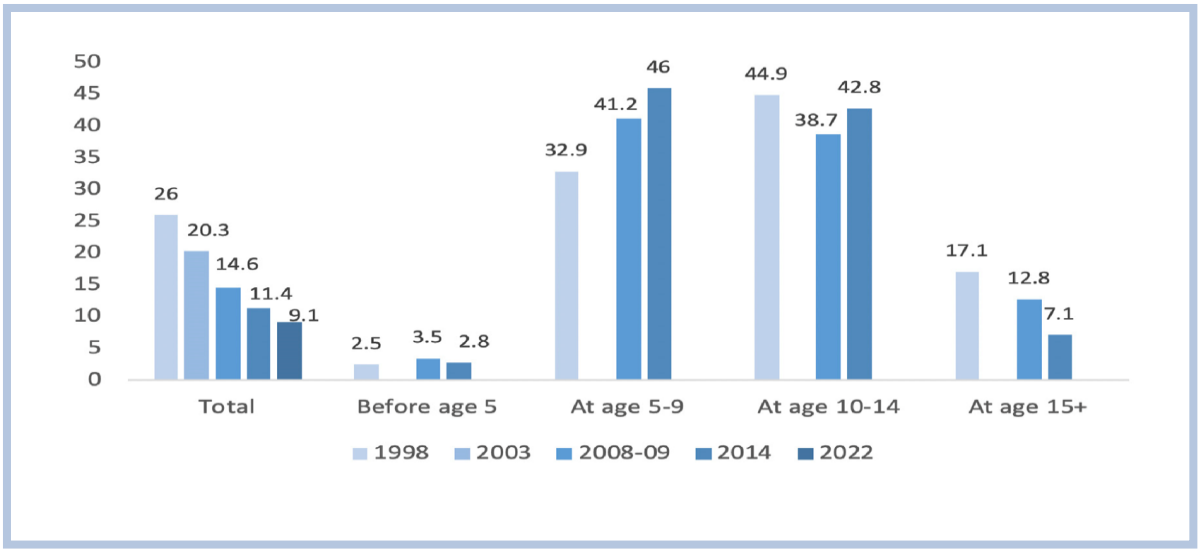
The sexual and gender-based violence among adolescent girls persists but is decreasing. Thirty-four percent of women in Kenya have experienced physical violence since age 15, including 16% who experienced physical violence often. The percentage of women who experienced

[72] African Institute for Policy Development (AFIDEP) (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023

physical violence however, declined from 20% in 2014 to 16% in 2022. Experience of violence among women increased with age; 20% of women age 15–19 experienced physical violence since age 15, as compared with 42% of women age 45–49. Marital status is linked to experiences of violence among women. Women who have ever been married are much more likely to have experienced violence since age 15 than those who have never been married (41% versus 20%). 13% of women reported that they had experienced sexual violence at some point in their lives, and 7% reported that they had experienced sexual violence in the last 12 months. The percentage of women who have experienced sexual violence increased with age, from 7% among those age 15–19 to 18% among those age 40–49. By county, the percentage of women who have experienced physical violence since age 15 was highest in Bungoma (62%) and lowest in Mandera (9%) while the percentages of women who experienced sexual violence were highest in Bungoma (30%), Murang'a (24%), Homa Bay (23%), and Embu (22%).[73]

Female genital mutilation/cutting (FGM/C) among adolescent girls ages 15-19 years declined between 1998 and 2022 (Figure 6). The prevalence of FGM/C declined from 38% in 1998 to 15% in 2022. Since 2014, the percentage of circumcised women who were cut and had flesh removed declined from 87% to 70%, while the percentage of circumcised women sewn closed increased from 9% to 12%. The prevalence of FGM generally increases with age; 9% of women age 15–19 have been circumcised, compared with 23% of women age 45–49. The FGM/C rate is highest at ages 5-9 years and 10-14 years. The FGM/C rate at ages 5-9 years increased between 1998 and 2022 from 32.2% to 46% and oscillated at ages 10-14 years from 44.9% in 1998 downwards to 38.7% in 2008-09 and then upwards to 42.8% in 2014.

Figure 8: Girls ages 15-19 years circumcised (%)



Source: African Institute for Policy Development (AFIDEP) (2023), Adolescent Sexual and Reproductive Health in Kenya: Status and Trends, FACTSHEET, March 2023

[73] Kenya National Bureau of Statistics (2023), Kenya Demographic and Health Survey 2022, Key Indicators Report, January 2023

5. Social determinants and barriers to AGYW access to SRHR services

The social determinants for SRH health outcomes amongst adolescents and young women include the conditions in which the individuals are born, grow, live, work and age. These conditions can be structural (national wealth, income inequality, educational opportunities and other national infrastructures), and proximal determinants that flow from the structural (neighborhood environment, family factors, social support, etc.). Social determinants work at different levels to influence exposure to the risks of unintended pregnancy or sexually transmitted inflection, care- seeking behavior, and access to and use of preventive services, care and treatment.[74] Sexual and reproductive health matters especially pertaining to adolescents and young women are contentious and arouse strong feelings and provoke disagreements wherever they are discussed.

The SRH challenges have major health, psychological, social and economic consequences and greatly compromise adolescent and young women's ability to realize their potential and stand in the way of the country's realization of the demographic dividend by: causing morbidity and mortality with massive economic costs; compromising education attainment (transition, retention and completion); and compromising the ability of young people to live productive lives; and increasing dependency.

The poor health outcomes among adolescents and young women are attributed to several barriers that they face in accessing sexual and reproductive health and HIV services, including lack of information, cost-related barriers, distance to health facilities, socio-cultural factors, and legal and policy-related barriers. In instances where services are accessible, provider biases coupled with concerns around privacy and confidentiality, deter adolescents and young women from seeking services. Adolescents and young women lack correct and comprehensive information on key sexual and reproductive health and rights (SRHR) issues including HIV/AIDS and harmful cultural practices. They also encounter many barriers in accessing SRH services due to lack of essential health commodities and services, lack of access to adolescent and youth friendly services; poor attitude of service providers; and barriers to participation and influencing decisions among others. This situation points to the fact that adolescents are underserved and underequipped to face challenges related to their sexual and reproductive rights.[75]

From the foregoing, adolescents and young women face inter-related barriers that prevent them from accessing especially facility-based SRH services. The key barriers include:

a) **Individual barriers,** such as feelings of shame, fear or anxiety about issues related to sexuality and reproduction, lack of awareness about the services available, poor health, or advice-seeking behaviors and the perception that services will not be confidential;
b) **Socio-cultural barriers**, such as social norms which dictate the behavior and sexuality of both young men and women, stigma surrounding sexually active adolescents, cultural barriers which limit the ability of women, girls or certain sub-sets of the population from accessing health services, educational limitations, language

[74] Malarcher, S. and World Health Organization, 2010. Social determinants of sexual and reproductive health: Informing future research and programme implementation.
[75] UNFPA, Adolescents Sexual and Reproductive Health Development Impact Bond. https://kenya.unfpa.org/en/ASRHDIB

differences, the attitudes of health care providers towards adolescents or their unwillingness to attend to their SRH needs; and

c) **Structural barriers**, such as long distances to health facilities, lack of facilities for clients with disabilities, inconvenient hours of operation, long waiting times, charging fees for services and lack of privacy.

SRH service providers must hence institute innovative approaches in order to make services acceptable, accessible and appropriate for adolescents, taking cultural sensitivity and diversity into consideration. Adolescents and young women should be involved as much as possible in the design, implementation and monitoring of program activities, so that programs are more likely to respond to their SRH rights, needs and priorities and so that interventions are acceptable to them. Introducing adolescent friendly health services and involving adolescents in both the design and monitoring of these services will make facility-based RH services more accessible and acceptable to adolescents. In addition, health service providers should consider alternative implementation strategies such as community interventions that will make it easier to reach adolescents with RH information and services.

6. Policy and legal framework for SRHR

Broadly, Kenya has evolved a supportive legal and policy environment for Sexual and Reproductive Health and Rights through development of a range of policy and legislative frameworks. The Constitution of Kenya 2010 guarantees every person the right to reproductive health care services.[76] In 1994, Kenya committed to implementing the International Conference on Population and Development (ICPD) Programme of Action, which placed the rights of women and girls including their sexual and reproductive health and rights at the center of development.[77] Kenya is also signatory to the 2013 Eastern and Southern Africa (ESA) commitment to scale up Comprehensive Sexuality Education (CSE) and youth-friendly Sexual Reproductive Health (SRH) services for adolescents and young people in the region.[78]

6.1 International and regional frameworks

Articles 2(5) (6) & 21(4) of the Constitution of Kenya 2010 elevates the status and application of the general rules of international law and any treaty or convention ratified by Kenya as part of the laws of Kenya. Kenya has ratified key international and regional treaties, conventions and declarations that uphold adolescents and young people's sexual and reproductive health and rights. These include the UN Convention on the Rights of the Child (UNCRC) ratified 1990, the African Charter on the Rights and Welfare of the Child (1990), and the 1994 International Conference on Population and Development (ICPD) Program of Action. These have formed the basis for the development of national policies and legislation on sexual and reproductive health in Kenya.

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[76] Republic of Kenya, National Council for Law Reporting (Kenya Law). Constitution of Kenya, 2010. Available from: http://kenyalaw.org/lex/actview.xql?actid=Const2010

[77] UNFPA. International Conference on Population and Development. Available from: https://www.unfpa.org/icpd

[78] UNESCO. Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA). FINAL VERSION AFFIRMED 7th December 2013. Available from: https://healtheducationresources.unesco.org/sites/default/files/resources/ESACommitmentFINALAffirmedon7thDecember.pdf

Under the international law, States have the duty to protect the human rights of their citizens. The human rights that relate to sexual and reproductive health include the right to health; the right to life; the right to education and information; the right to clean and safe water and reasonable standards of sanitation; the right to privacy; the right to decide the number and spacing of children; the right to consent to marriage & to equality in marriage; the right to be free from discrimination; the right to be free from practices that harm women and girls; and the right to be free from violence.

Broadly, the human rights of adolescent girls and young women, including vulnerable sub-groups, are protected under several international declarations and conventions including the following:

a) **Universal Declaration on Human Rights:** The Universal Declaration on Human Rights[79] declares that all human beings are born free and equal in dignity and rights. Everyone has the right to life, liberty and security of person. The Universal Declaration of Human Rights (UDHR) mentions the right to health under the right to the highest attainable standard of living (UDHR Article 25). Ensuring the right to health includes the right to sexual and reproductive health which is the responsibility of States to ensure that it is promoted, protected and fulfilled and that those who are marginalized or most at-risk in the population are provided with access to quality healthcare.[80]

b) **The UN Convention on the Rights of the Child:** Under international law, adolescents have rights through the Convention on the Rights of the Child (CRC) until they reach 18 years of age. These include the right to reproductive health (RH) information and services as well as protection from discrimination, abuse and exploitation. The rights of the child that relate to ASRH include[81]:

   (i) The right to the highest attainable standard of health, including the right to reproductive health.
   (ii) The right to impart and receive information and the right to education, including complete and correct information about SRH.
   (iii) The right to confidentiality and privacy, including the right to obtain RH services without consent of a parent, spouse or guardian. Conducting a virginity (hymen) examination on an adolescent without her consent would also be a violation of this right.
   (iv) The right to be free from harmful traditional practices, including female genital cutting and forced early marriage.
   (v) The right to be free from all forms of physical and mental abuse and all forms of sexual exploitation, including sexual and domestic violence.
   (vi) The right to equality and non-discrimination, including the right to access RH services, regardless of age or marital status and without consent of parent, guardian or spouse.

[79] United Nations. *Universal Declaration of Human Rights*. http://www.un.org/en/documents/udhr/index.shtml.
[80] WHO, 1946
[81] Save the Children and UNFPA (2009), Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, September 2009

(vii) All actions taken should be in the best interest of the child. For example, requiring parental consent for contraception or obstetric care, or refusing services because of age would not be in the best interest of the adolescent.

The UN Committee on the Rights of the Child issued General Comment No. 4, 2003 provides adolescents with the right to information related to SRH, "regardless of their marital status and whether their parents or guardians consent" (paragraph 28). Health providers have the obligation to provide adolescents with private and confidential advice so that they are able to make informed decisions about treatment (paragraph 33).

c) **The 1994 Cairo International Conference on Population and Development**: The 1994 Cairo International Conference on Population and Development[82] defined reproductive health and the right to reproductive health as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. At the 25th ICPD Conference held in Nairobi Kenya from 12th to 14th November 2019, Governments further reaffirmed their commitment to fully implementing the 1994 ICPD Program of Action noting that Sustainable Development Goals could not be attained unless the commitments of the ICPD Program of Action were met. The commitments center around the following:

(i) Achieving universal access to sexual and reproductive health rights as part of universal health coverage. This includes zero unmet need for family planning information and services, zero preventable maternal deaths and morbidities, comprehensive and age–responsive information, education and adolescent–friendly comprehensive, quality and timely services;
(ii) Addressing sexual and gender-based violence and harmful practices including zero sexual and gender-based violence and harmful practices, elimination of all forms of discrimination against all women and girls;
(iii) Mobilization of the required financing to complete ICPD Programme of Action and sustain the gains already made;
(iv) Drawing on demographic diversity to drive economic growth and achieve sustainable development; and
(v) Upholding the right to sexual and reproductive health services in humanitarian and fragile contexts.

d) **The United Nations Fourth World Conference on Women. "Platform for Action," 1995:** The 1995 Platform for Action[83] expanded the definition of reproductive health to include sexuality: The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

e) **UN Convention on the Rights of Persons with Disabilities**[84]**:** Adolescents with disabilities are protected under the UN Convention on the Rights of Persons with

[82] United Nations. *International Conference on Population and Development*. "Summary of the Programme of Action," http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm
[83] United Nations. *The United Nations Fourth World Conference on Women*. "Platform for Action," 1995. http://www.un.org/womenwatch/daw/beijing/platform/health.htm
[84] *UN Convention on the Rights of Persons with Disabilities*

Disabilities.[85] The Convention on the Rights of Persons with Disabilities states that States shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others. It further states that people with disabilities have the right to the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population based public health programmes.[86]

f) The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa: The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[87], better known as the Maputo Protocol was adopted by the 2nd Ordinary Session of the Assembly of the African Union in Maputo on 11 July 2003 and came into effect in 2005. The Maputo Protocol is the most progressive legal instrument providing a comprehensive set of human rights for African women.[88]
Article 14 of the Maputo Protocol on Health and Reproductive Rights guarantees the respect and promotion of women's right to health, including sexual and reproductive health (SRH). The Article also addresses women's right to self-protection and to be protected from HIV, and to be informed of their health status and that of their partner. It further defines women's reproductive freedoms, right to choose contraceptive methods and the right to access education on measures to control their fertility. It mandates State Parties to provide health services, including information and education as well as ante and postnatal and delivery services. The Protocol further mandates State Parties to authorize medical abortion on specified grounds. Specifically, Article 14.1 of the Protocol provides that State Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

(i) the right to control their fertility;
(ii) the right to decide whether to have children, the number of children and the spacing of children;
(iii) the right to choose any method of contraception;
(iv) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
(v) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
(vi) the right to have family planning education.

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[85] Save the Children and UNFPA, Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, September 2009

[86] United Nations. *The Right to Reproductive and Sexual Health*. 1997. http://www.un.org/ecosocdev/geninfo/women/womrepro.htm

[87] African Union (2003), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Adopted by the 2nd Ordinary Session of the Assembly of the African Union, Maputo, 11 July 2003.

[88] African Union Commission (2016), Maputo Protocol on Women's Rights: A Living Document for Women's Human Rights, submitted by the Women, Gender and Development Directorate (WGDD) of the African Union Commission as part of a presentation on the "State of Ratification of the Maputo Protocol" during the AU Ministerial Consultation Meeting held on 18 March 2016, on the margins of the 60th Session of the United Nations Commission on the Status of Women (CSW), in New York, USA. http://www.peaceau.org/uploads/special-rappor teur-on-rights-of-women-in-africa-presentation-for-csw-implementation. pdf accessed on 14/05/2016 11h49.

Article 14.2 of the Protocol provides that State Parties shall take all appropriate measures to:

a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
c) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

The State obligation to protect and to promote women's enjoyment of sexual and reproductive rights requires states to both remove obstacles and create an enabling environment. Eliminating stigmatisation and discrimination related to reproductive health is essential for the promotion of women and girls' rights to contraception and safe abortion services. This entails supporting women's empowerment; sensitising and educating communities, religious leaders, traditional chiefs and political leaders on women's sexual and reproductive rights; and training health care workers.

g) Sustainable Development Goals: The Sustainable Development Goals 3 and 5 set out the global agenda for SRHR. They include several targets related to health, education, gender equality and empowerment of women and girls. Specifically, under SDG 3 (ensure healthy lives and promote wellbeing of all ages), SDG Target 3.7 calls for ensuring universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030. The SDG 5 Target 5.6 on gender equality and women empowerment seeks to ensure universal access to sexual and reproductive health and reproductive rights agreed in accordance with the Programme of Action of the International Conference on Population and Development. Other relevant SDG targets include: ending preventable deaths of newborns and children under 5 years of age (target 3.2); and eliminating all harmful practices, such as early and forced marriage and female genital mutilation (target 5.3).

6.2 Constitutional and legal framework

Kenya has established a favorable constitutional and legal context for addressing the sexual and reproductive health and rights (SRHR).

6.2.1 The Constitutional Framework

The Constitution of Kenya under Article 43 (1) (a) and (2) guarantees the right of every person to the highest attainable standard of health, which includes the right to health care services, including reproductive health care as well as the right not to be denied emergency medical treatment. Article 26(4) outlines broad legal framework with regard to safe and post-abortion care. It allows abortion where in the opinion of a trained health professional there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law. Article 35 (1) (b) provides every citizen the right of access to information held by another person and required for the exercise or protection of any right or fundamental freedom.

Article 53 (1) (c) and (d) guarantees every child the right to health care and to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour. Article 55(d) of the Constitution further requires the State to take measures, including affirmative action programmes, to ensure that the young people are protected from harmful cultural practices and exploitation. Article 56(e) also requires the State to put in place affirmative action programmes designed to ensure that minorities and marginalised groups have reasonable access to water, health services and infrastructure. Article 45 (2) of the Constitution of Kenya set the minimum age of free consent to sexual activity and marriage at 18 years for both girls and boys.

Article 21 requires the State to take necessary legislative, policy and other measures, including the setting of standards, to achieve the rights guaranteed under Article 43 and to fulfill Kenya's international obligations[89] in respect of human rights and fundamental freedoms. It further obligates the State to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities, and members of particular ethnic, religious or cultural communities. Article 20 (5) (a) (b) requires the State to commit resources to the progressive realization of the rights guaranteed under Article 43 and in allocating resources, must give priority to ensuring their widest possible enjoyment having regard to prevailing circumstance, including the vulnerability of particular groups or individuals. To ensure that the rights are respected and enforced, the Constitution under Article 22 gives every person the right to institute court proceedings claiming that his/her right has been denied, violated or infringed, or is threatened. On application, the court or tribunal may make any order, or give any directions, it considers appropriate including providing compensation for any victim of a violation of the right.

The Constitution outlines the immutable values and principles of governance which all State organs, officers and persons must comply with in the governance, management and delivery of services. These values and principles are outlined in Preamble, Articles 1 (Sovereignty of the People), 2(Supremacy of the Constitution), 3 (Defense of the Constitution),10 (National Values and Principles of Governance), 175(Principles of Devolved Government), 201(Principles of Public Finance) and 232 (Values and Principles of Public Service) and Chapters 6 (Leadership and Integrity), among others.

Article 174 of the Constitution provides the principles and objects of the devolved system of government in Kenya. Functionally, Articles 6, 186 and the Fourth Schedule of the Constitution assign and demarcate powers, functions and relationship between national and county governments. Whereas the National government is responsible health policy; national referral health facilities; capacity building and technical assistance to counties, the county governments are responsible for County health services which include county health facilities and pharmacies; ambulance services and promotion of primary healthcare among others. The staffing of county governments is to be conducted within the framework of the norms and standards set by the National government in accordance with the relevant legislation and policies. Articles 189-191 of the constitution provide for the cooperation between national and county governments, national government support to county governments, and conflict of laws between different levels of government.

[89] Article 2(6) of the Constitution recognises ratified international treaties or conventions as part of the laws of Kenya.

Alongside the division of functions between the national and county governments under the Fourth Schedule, the Constitution of Kenya 2010 assigns fiscal powers to the two levels of government. Article 209 (4) of the Constitution gives national and county governments the power to impose charges for services they may provide. Article 175(2) of the Constitution provides that county governments shall have reliable sources of revenue to enable them to govern and deliver services assigned to the county governments under the Fourth Schedule effectively. The basis of fiscal devolution is the principle that funds must follow and match functions in order to avoid mismatch between functional responsibilities, plans and allocation of available resources at and between national and county governments (Article 187(2)(a)).

6.2.2 The Legal Framework

The key legislative provisions for the SRHR in Kenya include Health Act 2017, Sexual Offences Act (2006), Children's Act (2022), Counter Trafficking in Persons Act (2010), Prohibition of FGM Act (2011), Persons with Disabilities Act (2003), HIV and AIDS Prevention and Control Act (2006), Protection against Domestic Violence Act 2015 and Marriage Act (2014).

The Health Act No. 21 of 2017 under section 4 restates the fundamental duty of the State to observe, respect, protect, promote and fulfill the right to the highest attainable standard of health including reproductive healthcare and emergency medical treatment by inter alia - ensuring the realization of the health related rights and interests of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities and members of particular ethnic, religious or cultural communities. Section 5 (3) (b) of the Act provides that the national and county governments shall ensure the provision of free and compulsory maternity care. Section 6 (1) of the Health Act defines the right to reproductive health care to include—

a) the right of men and women of reproductive age to be informed about, and to have access to reproductive health services including to safe, effective, affordable and acceptable family planning services;
b) the right of access to appropriate health-care services that will enable parents to go safely through pregnancy, childbirth, and the postpartum period, and provide parents with the best chance of having a healthy infant;
c) access to treatment by a trained health professional for conditions occurring during pregnancy including abnormal pregnancy conditions, such as ectopic, abdominal and molar pregnancy, or any medical condition exacerbated by the pregnancy to such an extent that the life or health of the mother is threatened. All such cases shall be regarded as comprising notifiable conditions.

Sect 6 (3) of the Health Act, 2017 provides that any procedure carried out in terms of reproductive health services including safe, effective, affordable and acceptable family planning services and treatment of pregnancy including abnormal pregnancy conditions, such as ectopic, abdominal and molar pregnancy, or any medical condition exacerbated by the pregnancy to such an extent that the life or health of the mother is threatened shall be performed in a legally recognized health facility with an enabling environment consisting of the minimum human resources, infrastructure, commodities and supplies for the facility as defined in the norms and standards developed under the Act. Table 5 below presents the summary of key legal frameworks and principles that are relevant to AGYWs.

Table 5: Key legal frameworks for SRHR in Kenya

Legal Instrument	Principles relevant to AYPSRH
Health Act 2017	● It is the implementing law on right to health in Kenya with emphasis on adherence to protection of human dignity while providing a scope of health services to cover preventive, curative and rehabilitative ● Section 4 states the fundamental duty of the State to observe, respect, protect, promote and fulfil the right to the highest attainable standard of health including reproductive healthcare ● Section 6. (1) States that every person has a right to reproductive health care ● Section 9 (3) defines "informed consent" as consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as provided for in section 8 of this Act. (children/adolescents have no legal capacity to give consent) ● Section 68 (1)(e) states that the National health system shall devise and implement measures to promote health and to counter influences having an adverse effect on the health of the people including (e) a comprehensive programme to advance reproductive health including— (i) effective family planning services; (ii) implementation of means to reduce unsafe sexual practices; (iii) adolescence and youth sexual and reproductive health; (iv) maternal and neo-natal and child health; (v) elimination of female genital mutilation; (vi) maternal nutrition and micro nutrient supplementation.
Public Health Act Cap 242	● Section 46(1) and (2) of the Public Health Act requires parents to ensure they treat their children against venereal diseases and it is an offence not to do so.
Children's Act 2021	● The Act safeguards the rights and best interests of children in Kenya. ● Defines a child as a person below the age of 18 years: Defines FGM, Forced Male Circumcision, Child Marriage, Child trafficking, radicalization, Vulnerable Child and actions that constitute child abuse: ● Section 4(1&2)- Children Act shall prevail in the case of any inconsistency between this Act and any other legislation on children matters unless the provision is of greater benefit in law to a child; ● Section 63(1) - Establishment of children rescue centers in every county for the temporary care of children in need of care and protection pending placement in Alternative care or other interventions. ● Section 142-145-Recognizes vulnerable children and provides for how best to address their concerns. It outlines the categories of children who are considered to be in **need of care and protection and how matters concerning them should be dispensed with.** ● The Act makes provision of social security to children through an elaborate Child Welfare Fund, which is to be funded through the national exchequer under the aegis of the Public Finance Management Act. The Act expressly mandates County Governments to establish child welfare schemes and child care facilities in their respective counties besides taking charge of pre-primary education.

	● The Act further makes provision of diversion, which essentially means that children who commit minor offences should not be directly taken through the criminal justice system but would be dealt with through community- based support systems. It also proposes to raise the age of criminal responsibility from eight to twelve years and makes it mandatory for children in conflict with the law, and those in the legal process to have legal aid. The Act makes it mandatory for police stations to have child protection units to ensure that children are not detained in the same facilities as adults.
Marriage Act 2014,	● Considers marriage with a child as a Void Marriage ● Section 11(1) Married parties treated as if there was no marriage at all if the child is underage,
Prohibition of FGM Act 2011	● Part IV of the Act criminalizes female genital mutilation (FGM); ● Section 19(1-2) provides that if FGM is carried out and causes death, the perpetrator will be liable to imprisonment for life.; ● Section 20 criminalizes individuals who aid or abate FGM.' ● Section 21 of the Act criminalizes cross-border migration for purposes of procurement of FGM
Sexual Offences Act 2017	● The Sexual Offences Act (SOA) complements the Children Act with regard to the protection of children from various sexual offences. It provides for the prevention of and protection of all persons from harmful and unlawful sexual acts. ● The Act makes provision about sexual offences, their definition, prevention and the protection of all persons from harm from unlawful sexual acts, and for connected purposes. ● Protects adolescents from sexual abuse – namely incest, defilement and rape and other sexual exploitation including offences relating to child sexual grooming and child pornography. ● The Act also criminalises the purchase of sexual services, has provisions regarding the giving of evidence by victims in sexual offence trials, offence addressing public indecency, maintaining the age of consent to sexual activity at 17 years of age and for a new "proximity of age" defence as well as a statutory statement of the law as regards consent to sexual acts. ● It defines and penalizes acts of penetration into sexual organs as defilement and rape. ● Sections 14 and 15 of the Sexual Offenses Act of 2006 criminalized the facilitation of child sex tourism and "child prostitution" and prescribed punishment of no less than 10 years' imprisonment, two million shillings.
Counter Trafficking in Persons Act (2010)	● The Counter-Trafficking in Persons Act of 2010 criminalizes sex trafficking and labor trafficking and prescribed penalties of 30 years to life imprisonment, a fine of not less than 30 million Kenyan shillings.
Person with Disability Act 2003 revised 2012.	● Section 20 requires implementation of the national health programme under the Ministry responsible for health for the purpose of – a) prevention of disability; b) early identification of disability; c) early rehabilitation of persons with disabilities; d) enabling persons with disabilities to receive free rehabilitation and medical services in public and privately owned health institutions;

	e) availing essential health services to persons with disabilities at an affordable cost; f) availing field medical personnel to local health institutions for the benefit of persons with disabilities; and g) prompt attendance by medical personnel to persons with disabilities. ● Section 21 promotes creation of - free and disability- friendly environment to enable them to have access to buildings, roads and other social amenities, and assistive devices and other equipment to promote their mobility. with disabilities in such manner as may be specified by the Council
HIV and AIDS Prevention and Control Act (2006),	● The Act has made provisions for testing of children, release of results and disclosure of information concerning results of a test or assessments in section 14,18 and 22 respectively ● Provide for measures for the prevention and containment of HIV and AIDS among the population ● Section 14 (1) (b) of the HIV prevention and Control Act provides that a child's parent/legal guardian must consent to their testing, provided that any child who is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV may, in writing, directly consent to an HIV test. (It lists children who have been defiled can give consent but doesn't categorize them according to age and only applies to testing of HIV, release and disclosure of information. ● Section 18 (b) of the HIV prevention and Control Act provides that a HIV result can only be released to a parent/legal guardian of the child.

6.3 National policy framework

Kenya has evolved a supportive policy environment for reproductive health and rights through development of a range of policy frameworks and guidelines. These include the Kenya Vision 2030, the Kenya Health Policy 2014-2030, the National Reproductive Health Policy 2022-2032, the National Adolescent Sexual and Reproductive Health Policy, 2015, the Sessional Paper No. 3 on Population Policy for National Development (2012), the Education Sector Policy on HIV and AIDS (2013) and the National School Health Policy (2009) among others.

The Kenya Vision 2030: The National Blueprint – Vision 2030 provides government's vision of 'Investing in All People of Kenya '. Under the Social Pillar, the Kenya Vision 2030's vision for health is to provide "equitable and affordable health care at the highest affordable standard" to all citizens. In order to reduce health inequalities and reverse the downward trends in the health related impact and outcome indicators, the Vision 2030 aims to among others:

a) Provide a functional, efficient and sustainable health infrastructure by ensuring that all health facilities are rehabilitated and fully equipped; new physical facilities are developed; and availability of quality health services improved;
b) Improve the quality of health care delivery to international standards and make Kenya a regional health service hub with world class medical centres;
c) Develop equitable health financing mechanism and social health insurance scheme to reduce out of pocket expenditure and ensure universal health coverage;
d) Reduce the shortage of human resources for health (HRH) by increasing the number and cadre of health personnel and improving working conditions; and

e) Promote public-private partnerships.

The Kenya vision 2030 further aims to - provide defined health services at the community level and strengthen health facility-community linkages; enhance the promotion of individual health and lifestyle; promote preventive health care services; and improve management and regulation of health care services across all levels.

Kenya Health Policy 2014-2030: The Kenya Health Policy, 2014–2030 gives directions to ensuring significant improvement in overall status of health in Kenya in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and global commitments. The Policy emphasizes a comprehensive rights-based approach to health services delivery with the focus on the provision of promotive, preventive, curative and rehabilitation services. The goal of the Policy is *"to attain the highest possible standard of health in a responsive manner."* The Kenya Health Policy 2014–2030 aims to:

a) Eliminate communicable conditions;
b) Halt and reverse the rising burden of non-communicable conditions;
c) Reduce the burden of violence and injuries;
d) Provide essential healthcare;
e) Minimize exposure to health risk factors; and
f) Strengthen collaboration with private and other health-related sectors.

The National Reproductive Health Policy 2022-2032: The National Reproductive Health Policy 2022-2032[90] aims to achieve universal Reproductive Health coverage through quality and comprehensive Reproductive Health interventions across the country; improve responsiveness to client's reproductive health needs; and strengthen the enablers (Health Systems Building Blocks) for Reproductive Health, including aligning partnerships and collaboration. The Policy targets all persons including children, adolescents, young persons, adults and older persons in need and requiring RH interventions. The Policy focus on 13 key aspects as follows

a) Reduction of maternal, perinatal and neonatal morbidity and mortality
b) Reduction of unmet family planning needs
c) Reduction of the burden of reproductive tract infections (RTIs) and improving access to, and quality services
d) Reduction of the HIV and AIDS burden and accelerate reversal of mother to child transmission of HIV
e) Reduction of morbidity and mortality associated with the common cancers of the reproductive organs in men and women
f) Harnessing digital technology to integrate evidence-based platforms such as telemedicine and self-care to ensure access to RH care to al
g) Mainstreaming special RH needs of marginalized populations [persons living with disabilities, elderly, people in humanitarian settings and correctional institutions].
h) Promoting gender equity, address Female Genital Fistula (FGF), eliminate FGM and eradicate all forms of gender-based violence and harmful reproductive health practices
i) Improving sexual and reproductive health outcomes among adolescents and youths

[90] Ministry of Health (2022), The National Reproductive Health Policy 2022 - 2032, Government of Kenya, July 2022.

j) Improving Menstrual Hygiene Management for girls and women
k) Reduction of infertility and increasing access to effective management of infertile individuals and couples
l) Ensuring that persons born intersex attain the highest standards of reproductive health.
m) Strengthening research development and innovation, and use of research evidence for RH interventions

The National Adolescent Sexual and Reproductive Health Policy, 2015: The National Adolescent Sexual and Reproductive Health Policy, 2015[91] under review, aimed to enhance the SRH status of adolescents in Kenya and contribute towards realization of their full potential in national development. Specifically, the objectives of the Policy were to:

a) Promote an enabling legal and socio-cultural environment for provision of SRH information and services for adolescents;
b) Enhance equitable access to high quality, efficient and effective adolescent friendly ASRH information and services;
c) Increase gender equity and equality in SRH amongst adolescents;
d) Strengthen inter-sectoral coordination and networking, partnership and community participation in adolescent SRH;
e) Support adolescent participation and leadership in SRH planning and programming at all levels; and
f) Strengthen collection, analysis, and utilization of age and sex disaggregated data on adolescents.

The Policy outlined the guiding principles and priority actions for ASRH in Kenya including:
a) promoting adolescent sexual reproductive health and rights;
b) increasing access to ASRH information and age appropriate comprehensive sexuality education (AACSE);
c) reduction of STIs burden, including HPV and HIV as well as improvement of appropriate response for infected adolescents;
d) reducing early and unintended pregnancies;
e) reducing harmful traditional practices;
f) reducing drug and substance abuse;
g) reducing Sexual and Gender-Based Violence (SGBV) incidences amongst adolescents to improve response; and
h) addressing the special SRHR-related needs of marginalized and vulnerable adolescents.

The management and coordination, provision of ASRH services, roles and responsibilities of various sectors and stakeholders, research and utilization of evidence-based interventions as well as monitoring and evaluation are spelt out in the policy implementation framework. Table 6 presents the summary of key national policy frameworks and guidelines relevant to AYPRH SRHR.

[91] MOH, National Adolescent Sexual and Reproductive Health Policy, 2015

Table 6: Summary of key national policy frameworks and guidelines relevant to AGYW SRHR

Policy Instrument	Relevance to AYPRH
Kenya Health Policy (2014-2030)	● Provides directions to ensure significant improvement in overall status of health in Kenya in line with the Constitution of Kenya 2010 ● Confirms a basis for the human rights approach to adolescent health
Kenya Vision 2030	● Development blueprint that seeks to transform Kenya to providing a high quality of life to all its citizens in a clean and secure environment. Through vision 2030 social pillar, Kenya commits to improve the quality of life for all Kenyans by targeting gender equality programmes.
The National Reproductive Health Policy (2021)	● Provides guidelines to address reproductive health issues in Kenya ● Objective 3.4.9 focuses on actions to address adolescents sexual reproductive health
Kenya's Demographic Dividend Roadmap 2020-2030	● Provides a roadman to harness demographic dividend through investment in the youth
Plan of Action for Addressing Teenage Pregnancy 2021	● Provides guidelines on implementation of programs to address teenage pregnancy
National Policy for the Eradication of Female Genital Mutilation -2019	● Affirms that every girl and woman has the right to be protected from this harmful practice, a manifestation of entrenched gender inequality with devastating consequences. Female genital mutilation (FGM) is a violation of human rights.
National Menstrual Hygiene Management (MHM) Policy 2019-2030	● Advocates for menstrual hygiene incorporation in the various Reproductive Health programmes.
New-born, Child and Adolescent Health Policy 2018	● To provide policy guidance to accelerate reduction of newborn, child and adolescent deaths in Kenya and promote their health, development and wellbeing.
Mental Health Policy 2015-2030	● Seeks to address the systemic challenges, emerging trends and mitigate the burden of mental health problems and disorders.
National Policy on Gender-Based Violence (2014)	● -Seeks to accelerate efforts towards the elimination of all forms of GBV in Kenya. Through a coordinated approach in addressing GBV and effective programming; enforcement of laws and policies towards GBV prevention and response; increase in access to quality and comprehensive support services across sectors; and improved sustainability of GBV prevention and response interventions
National Children Policy 2010	● Aims to prevent child abuse and neglect by providing recommendations that promote and protect the rights of children in health, education, and other socio-cultural aspects
Education Sector Policy on HIV and AIDS (2013)	● Seeks to enhance knowledge on HIV and AIDS at all levels of education with a view to reducing new infection, stigma and discrimination in the education sector
National School Health Policy (2009)	● Recognizes the role of schools in the provision of health and nutrition services as well as a key avenue for disease prevention and control. ● Proposes a Comprehensive School Health Programme that meets health and psychosocial needs of learners in and out of school.

	Includes values and life skills; gender, growth and development; child rights, and responsibilities; water, sanitation and hygiene; special needs, disabilities and rehabilitation; and cross other cutting issues.
Kenya Youth Development Policy of 2019	● Seeks to provide an opportunity for improving the quality of life for the youth in Kenya.
Gender Policy in Education (2007)	- Promotes gender equality and empowerment of women ● -advocates for more equal participation between women and men, girls and boys
Guidelines	
National Guidelines for School Re-entry in Early Learning and Basic Education 2019.	● Provides a framework to enhance re-entry for learners who drop out of school, including those with special needs and disabilities, as well as girls who drop out due to early pregnancy
National Guidelines on Alcohol Drug Use Prevention 2021	● Provides evidence based interventions to cub drug and substance abuse
Guidelines for Conducting Adolescents SRH research 2015 (NASCOP-KEMRI)	● Recognises the importance of involving adolescents in SRH research and provides exceptions of parental consent for adolescents who are not under parental responsibility or may become vulnerable if parents/ guardians are consented
Kenya's Fast-track Plan to End HIV/AIDS Among AYPs (NACC, 2015)	● Recommends evidence-informed combination approaches to achieve goals that are expected to produce the highest returns on investment if implemented at scale.
The Kenya HIV Testing Services Guidelines, (NASCOP 2015)	● Lowered the age of consent for HIV testing services to 15 years to enable access to services without parental consent for minors engaging in HIVrisk behaviour
HIV Prevention Revolution Road Map: Count Down to 2030 (MOH, 2014)	● Identifies adolescents and young people as a priority population for HIV services and recommends a location-based approach to service provision. Interventions identified include activities and services for protection and provision of SRH services
National Guidelines for the provision of Adolescent and Youth Friendly Services (2016).	● Provides a framework for improving coverage of adolescent and youth friendly services through describing comprehensive services and outlining mechanisms for coordination, monitoring and evaluation.
Guidelines for HIV/STI Programming with Key Populations (NASCOP, 2014)	● Provides a framework to create an enabling environment and support adolescent key populations to reduce their risk of acquiring or transmitting HIV or STIs

Overall, despite the broadly enabling constitutional, legal and policy environment for the realization of the SRHR, poor sexual and reproductive health outcomes remain a reality for many adolescents and young people especially adolescent girls and young women (AGYW). According to WHO, although laws and policies exist that authorize and require the relevant authorities to deliver health and social interventions to adolescents, provide the basis for the formulation of strategies and budgets, and signal the position of political leadership and government on important SRHR issues, [92] this has not been adequately implemented. The

[92] World Health Organization (2018) WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: Licence: CC BY-NC-SA 3.0 IGO

reality is that neither the providers of these services nor the systems in which they operate are geared towards meeting the needs and fulfilling the rights of adolescents.[93]

According to Kenya National Commission on Human Rights report entitled "*Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality?,* violations of the right to sexual and reproductive health continue to be experienced throughout the country.[94]The SRH challenges have major health, psychological, social and economic consequences and greatly compromise adolescent girls and young women's ability to realize their potential and stand in the way of the country's realization of the demographic dividend by: causing morbidity and mortality with massive economic costs; compromising education attainment (transition, retention and completion); compromising the ability of adolescent girls and young women to live productive lives; and increasing dependency. However, one of the major obstacles to capturing the demographic dividend of the most educated and energetic youth (aged between 15 – 35) for African nations is the sexual and reproductive health and rights (SRHR) of adolescents and youth in the sub Saharan Africa, which is characterized by needs (UNFA 2019) high rates of adolescent pregnancies and a high proportion of unmet family planning.[95]

7. Dynamics of social accountability in adolescent and young women's SRHR

Social accountability is increasingly proffered as a key strategy to addressing health systems inefficiencies and improving planning, service delivery and health system performance towards the widest possible enjoyment of the health rights. Civil society organizations in particular see social accountability as one key approach to improving the realization of Sexual and Reproductive Health and Rights (SRHR).[96] The 2008 Accra Agenda for Action[97] and the 2005 Paris Declaration on aid effectiveness[98] emphasized the country's ownership of development policies through social accountability and citizen engagement. While social accountability is highly preferred as a panacea to promoting SRHR, there is however little evidence on its programmatic impact.[99] In most cases, the assumption of social accountability is that elected governments, from ministries to service providers, have a duty to their citizens, and citizens have the right to hold their representatives accountable for their duties.[100]

[93] World Health Organization (2018) WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: Licence: CC BY-NC-SA 3.0 IGO
[94] KNHRC (2012) Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality?
[95] UNFPA (2019) Adolescent and Youth Sexual and Reproductive Health and Rights Services Key elements for implementation and scaling up services in West and Central Africa.
[96] Victoria Boydell, Heather McMullen, Joanna Cordero, Petrus Steyn and James Kiare (2019), Studying social accountability in the context of health system strengthening: innovations and considerations for future work, Health Research Policy and Systems (2019) https://doi.org/10.1186/s12961-019-0438-x
[97] AFDB (2008), Accra Agenda for Action, 3rd High Level Forum on Aid Effectiveness, September 2-4 2008, Accra, Ghana. https://www.afdb.org/fileadmin/uploads/afdb/Documents/AccraAgendaAaction-4sept2008-FINAL-ENG_16h00.pdf
[98] OECD (2005), The Paris Declaration on Aid Effectiveness, Second High Level Forum on Aid Effectiveness, 2nd March 2005, Paris, France. https://web-archive.oecd.org/temp/2021-08-02/73869-parisdeclarationandaccraagendaforaction.htm
[99] Schaaf, M., Arnott, G., Chilufya, K.M. *et al.* Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations. *Int J Equity Health* **21** (Suppl 1), 19 (2022). https://doi.org/10.1186/s12939-021-01597-x
[100] IPPF (2013) A Guide to Using Community Score Cards for Youth-Led Social Accountability

7.1 What is Social Accountability?

Broadly, social accountability refers to ongoing and collective effort[s] to hold public officials to account for the provision of public goods which are existing state obligations."[101] Social accountability is also referred to as "citizens' efforts at ongoing meaningful collective engagement with public institutions for accountability in the provision of public goods.[102] According to the World Bank, social accountability is "an approach towards building accountability that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organizations who participate directly or indirectly in exacting accountability.[103] Social accountability includes a broad range of actions and mechanisms which rely on civic engagement which citizens can use to hold the state and duty bearers accountable.[104] Social accountability mechanisms complement and enhance conventional internal government mechanisms of accountability like internal audit units and quality assurance departments in health systems by providing a set of tools that young people can use to influence the quality of health service delivery by holding providers accountable.[105]

Social accountability is thus a citizen-led action to hold public officials and service providers to account for the use of public resources and services delivered. It provides an avenue for citizens to exercise their constitutional right to participate in decisions and processes concerning their own development.[106] It is a process and an approach in which citizens are engaged to hold leaders, policymakers, and public officials accountable for the services that they provide. It enables ordinary citizens or civil society organizations to participate directly or indirectly in demanding accountability.

Social accountability is an advanced form of community participation whereby citizens take action to enhance the accountability of politicians, policymakers and service providers. A key area of accountability is government or public accountability- a form of accountability builds on the implicit social contract between citizens and their delegated representatives. It is the obligation of power-holders to account for or to take responsibility for their actions. Social accountability processes are critical in ensuring that government services are delivered as planned and budgeted are of quality and good value for money for citizens.[107] Social accountability can play an important role in addressing corruption and increasing trust in public servants and government, which is key to accelerating efforts to achieve the Sustainable

[101] Houtzager P, Joshi A. Introduction: contours of a research project and early findings. IDS Bull. 2008;38(6):1–9. doi: 10.1111/j.1759 5436.2007.tb00413.x. [CrossRef] [Google Scholar]
[102]Joshi A. Legal empowerment and social accountability: complementary strategies toward rights-based development in health? World Dev. 2017; 99:160–72.
[103] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.
[104] World Bank (2004), Social Development Papers: Participation and Civic Engagement Paper No. 76 December 2004, World Bank.
[105] Dena Ringold, Alaka Holla, Margaret Koziol, Santhosh Srinivasan (2012) Citizens and Service Delivery: Assessing the Use of Social Accountability Approaches in the Human Development Sectors.
[106] Ahadi, Social Accountability, County Governance Toolkit. https://countytoolkit.devolution.go.ke/social-accountability
[107] Ahadi, Social Accountability, County Governance Toolkit. https://countytoolkit.devolution.go.ke/social-accountability

Development Goals (SDGs) and increasing the power and influence of citizens on agenda-setting.[108]

Social accountability interventions typically entail citizens and community actors assessing government performance against an agreed set of standards. They involve citizens and CSOs in public decision making; enables citizens and CSOs to articulate their needs to governments and service providers; brings the perspective of citizens and CSOs to government activities, such as policy making, the management of public finances and resources, and service delivery; and allows civil society to participate in monitoring the public sector and giving feedback on government performance. They also involve a deliberative consensus building or priority setting process, wherein community members discuss and identify priorities; two-way dialogue between communities and the health system about these priorities; and follow up to ensure that these priorities are addressed.[109]

Since social accountability is explicitly concerned with changing the power relationship between 'citizens' and the duty-bearers, the use of social accountability tools are inherently political even if they do not intend to be and hence can never be neutral.[110] Social accountability processes therefore aim to support service users to voice their needs, make claims to their entitlements and hold those responsible for the provision of services to account.[111]

In the context of healthcare, social accountability is a form of participatory citizen engagement where citizens are recognized as service users who are impacted by healthcare decisions, and as a consequence, they can effect changes in healthcare policies, healthcare services, and/or healthcare provider behavior through their collective influence and action.[112] However, in many instances, community participation, especially among women in accountability processes is fragmented.[113]

[108] McDougall, L. (2016). Power and Politics in the Global Health Landscape: Beliefs, Competition and Negotiation Among Global Advocacy Coalitions in the Policy-Making Process. International Journal of Health Policy and Management, 5(5), 309–320. https://doi.org/10.15171/ijhpm.2016.03

[109] Marta Schaaf, Grady Arnott, Kudzai Meda Chilufya, Renu Khanna, Ram Chandra Khanal, Tanvi Monga, Charles Otema, and Christina Wegs (2022), Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations, International Journal on Equity Health. 2022; 21(Suppl 1): 19.

[110] Victoria Boydell, Heather McMullen, Joanna Cordero, Petrus Steyn and James Kiare (2019), Studying social accountability in the context of health system strengthening: innovations and considerations for future work, Health Research Policy and Systems (2019) https://doi.org/10.1186/s12961-019-0438-x

[111] Joshi A. Legal empowerment and social accountability: complementary strategies toward rights-based development in health? World Dev. 2017; 99:160–72.

[112] Fox, J. A. (2015). Social Accountability: What Does the Evidence Really Say? World Development, 72, 346–361. https://doi.org/10.1016/j.worlddev.2015.03.011

[113] Hoope-Bender, P., Martin Hilber, A., Nove, A., Bandali, S., Nam, S., Armstrong, C., Ahmed, A. M., Chatuluka, M. G., Magoma, M., & Hulton, L. (2016). Using advocacy and data to strengthen political accountability in maternal and newborn health in Africa. International Journal of Gynecology & Obstetrics, 135(3), 358–364. https://doi.org/10.1016/j.ijgo.2016.10.003

7.2 Social accountability approaches and mechanisms

Social accountability processes feature multiple and interrelated components, steps and actors, with several simultaneous processes of triggering collective changes.[114] The social accountability processes share three broad components as a part of their theory of change, namely information, collective action and official response.[115] The key common building blocks of social accountability include obtaining, analyzing and disseminating information, mobilizing public support, and advocating and negotiating change. The citizen-driven accountability measures complement and reinforce conventional mechanisms of accountability such as political checks and balances, accounting and auditing systems, administrative rules and legal procedures.[116] Broadly social accountability is based on three key principles, namely transparency, accountability and participation.

Social accountability involves a broad range of actions, mechanisms and tools that citizens, communities, independent media and civil society organizations can use to hold public officials and public servants accountable and to trigger change.[117] These include community scorecard, social audits, citizen scorecard, gender budgeting, public expenditure tracking, public hearings, participatory planning and budgeting, audio-visual documentation of rights violations, monitoring of public service delivery, investigative journalism, public commissions and citizen advisory boards and citizen charters among others.

Social Accountability tools such as whistle-blower mechanisms, public hearings, and consultation, online and social media advocacy, complaints and feedback mechanisms, and open data platforms, empower communities and individuals to actively participate in governance and hold institutions accountable for their actions. The social accountability mechanisms and tools may vary in focus, looking either broadly at health systems or focusing on specific service delivery points, and they vary in engagement type from collaborative problem solving to more adversarial approaches. Below is a brief description of the various approaches and Tools for Social Accountability

Citizen Report Cards: Citizen Report Card (CRS) is a performance monitoring tool that collects citizen feedback on the performance of a given service based on their experience as users of such services. Information is collected through household and individual surveys in which citizens grade the overall quality of a service or facility. The findings present a quantitative measure of user satisfaction. Results are disseminated through the media and civil society.[118] By monitoring services and providing feedback, citizens can exact greater accountability and efficiency. Citizen Report Cards address critical themes in the realm of

[114] Moore GF, Audrey S, Barker M, Bond L, Bonell C, Hardeman W, et al. Process evaluation in complex public health intervention studies and the need for guidance. J Epidemiol Community Health. 2014; 68(2):101–2. https://doi.org/ 10.1136/jech-2013-202869.;

[115] Joshi A. Do they work? Assessing the impact of transparency and accountability initiatives in service delivery. Dev Policy Rev. 2013; 31:29–48.

[116] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

[117] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

[118] McCoy, D. C., Hall, J. A., & Ridge, M. (2012). A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. Health Policy and Planning, 27(6), 449–466. https://doi.org/10.1093/heapol/czr077

service delivery, such as access, quality, and reliability. They also highlight problems encountered by users of services and the responsiveness of service providers in addressing these problems. A CRC reveals the degree of transparency in service provision by documenting information such as the disclosure of service standards, and the costs incurred in using a service, including bribes. Finally, CRCs identify gaps in service delivery coverage and can form the basis of recommendations for action. Studies have shown that Community dialogues based on Citizen Report Cards (CRC) increased community awareness of available healthcare services, and their utilization and led to discussions on service delivery, barriers to service utilization, and processes for improvement.[119]

The Community scorecard: The community scorecard is where community members assess their existing entitlements in service delivery against an agreed set of standards and then prioritise the issues they face in accessing and delivering services.[120][121] The priorities identified are then jointly shared in multi-stakeholder meetings with health officials, health service providers and the community to identify local solutions and actions for service improvement and to promote mutual responsibility and accountability. Using the community scorecard tool, a community group may compile a scorecard delineating key elements of the public SHR strategy, assess gaps at their local health facilities, and, through a deliberative process, decide which gaps they wish to discuss with the county government; or, jointly agree on budget priorities in a participatory budgeting or budget monitoring process.[122]

Participatory Budgeting: Participatory Budgeting (PB) programs are innovative policymaking processes. Citizens are directly involved in making policy and budget decisions. Forums are held throughout the year so that citizens can allocate resources, prioritize broad social policies, and monitor public spending. These programs are designed to incorporate citizens into the policymaking process, spur administrative reform, and distribute public resources to low-income neighborhoods.[123] Governments and citizens initiate these programs to promote public learning and active citizenship; achieve social justice through improved policies and resource allocation; and reform the administrative apparatus.

Social Audit: A social audit can be defined as an approach and process to build accountability and transparency in the use and management of public resources. It is a mechanism where citizens organize and mobilize to evaluate or audit the government's performance and policy decisions. It rests on the premise that when government officials are watched and monitored, they feel greater pressure to respond to their constituents' demands and have fewer incentives

[119] Katahoire, A. R., Henriksson, D. K., Ssegujja, E., Waiswa, P., Ayebare, F., Bagenda, D., Mbonye, A. K., & Peterson, S. S. (2015). Improving child survival through a district management strengthening and community empowerment intervention: Early implementation experiences from Uganda. BMC Public Health, 15, 797. https://doi.org/10.1186/s12889-015-2129-z

[120] Gullo S, Galavotti C, Sebert Kuhlmann A, Msiska T, Hastings P, Marti CN. Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: A cluster randomized controlled evaluation. PLoS One. 2017;12(2):e0171316 https://doi.org/10.1371/journal.pone.0171316.

[121] Blake C, Annorbah-Sarpei NA, Bailey C, Ismaila Y, Deganus S, Bosomprah S, Galli F, Clark S. Scorecards and social accountability for improved maternal and newborn health services: A pilot in the Ashanti and Volta regions of Ghana. Int J Gynecol Obstet. 2016; 135:372–9.

[122] Marta Schaaf, Grady Arnott, Kudzai Meda Chilufya, Renu Khanna, Ram Chandra Khanal, Tanvi Monga, Charles Otema, and Christina Wegs (2022), Social accountability as a strategy to promote sexual and reproductive health entitlements for stigmatized issues and populations, International Journal on Equity Health. 2022; 21(Suppl 1): 19.

[123] Wampler, B. (2012). Participatory Budgeting: Core Principles and Key Impacts. Journal of Public Deliberation. https://scholarworks.boisestate.edu/polsci_facpubs/130

to abuse their power. Therefore, from the perspective of social audit, the critical questions and premise are whether citizens have the skills, capacity, and tools to effectively monitor and evaluate their governments and decision-makers.[124]

Whistle Blower Mechanism: According to (Whistle-blower Protection - OECD), encouraging citizens to report wrongdoing and to protect them when they do, is essential for corruption prevention in both the public and private sectors.[125] Employees/ Citizens are usually the first to recognize wrongdoing in the workplace. Empowering them to speak up without fear of reprisal can help authorities both detect and deter violations. In the public sector, protecting whistleblowers can make it easier to detect passive bribery, the misuse of public funds, waste, fraud, and other forms of corruption. In the private sector, it helps authorities identify cases of active bribery and other corrupt acts committed by companies and also helps businesses prevent and detect bribery in commercial transactions. Whistleblower protection is essential to safeguard the public interest and to promote a culture of public accountability and integrity.

Public Hearing and Consultation: Public hearings are usually not isolated events. Rather, they are the emerging, visible part of a larger process, both before and after the event itself. For example, social audits usually culminate in public hearings where the community/stakeholders gather in large numbers in the presence of government representatives and service providers to demand accountability and answers. This direct interaction process allows citizens to ask government officials questions about the discrepancies between entitlements and actual services to find out a legal way to problem solve. As such, public hearings are backed by hard evidence collected during social audits. An example could include town hall meetings.[126]

Social Media and Online Advocacy: The social media platforms offer unique tools to reach audiences. Using social media as an advocacy tool is most effective when you know what each platform offers and how to take advantage of it. Some of the most important tools include Facebook, Twitter and Instagram. In social accountability, social media platforms can be used for citizen mobilization, awareness, and advocacy on various issues including the provision of healthcare services.[127] Examples of social media and Online advocacy include campaigns, hashtags and online communities that focus on specific social accountability issues.

Complaints and Feedback Mechanism: In Kenya, Citizens can provide feedback to their governments, both the executive and national assembly through various ways. Citizen feedback is important as it helps to inform and guide the county government on what is working, what is not working, and areas that require attention or improvement. These mechanisms can be meaningful only if they are easily accessible, affordable, and appreciated by the government. Some formal mechanisms for citizen feedback include complaints forms,

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[124] Berthin, G. (2011). A Practical Guide to Social Audit as a Participatory Tool to Strengthen Democratic Governance, Transparency, and Accountability, UNDP, 2011.
[125] Whistleblower protection—OECD. (n.d.). Retrieved November 27, 2023, from https://www.oecd.org/gov/ethics/whistleblower-protection/
[126] Paul, S. (2019, December 13). Public Hearing: A peoples' court holds government accountable. CSA. https://www.civilsocietyacademy.org/post/public-hearing-peoples-court-to-hold-government-accountable
[127] Stowe, L. (2021, October 11). How to Build a Winning Social Media Strategy for Advocacy. VoterVoice. https://info.votervoice.net/resources/build-social-media-advocacy-campaign
Team. (2018, October 30). How Open Data Fosters Government Accountability. Opendatasoft. https://www.opendatasoft.com/en/blog/how-open-data-fosters-government-accountability/ten

presentation of petitions, presentation and submission of memoranda and public interest litigation.

Open Data Platforms: This involves making government data available to the public for scrutiny and analysis. Open government data encourages greater civic participation, which in turn leads citizens to demand that government officials and agencies take more responsibility for their actions and the outcomes.[128]

Health Facility Committees: Health Facilities Committees (HFCs) are defined as any structures that are constituted formally with community representation that has a clear link to a health facility and whose primary role is to enable community participation to improve the provision of better health service and health outcomes.[129] HFCs can exist at several levels and take different forms from village-level health committees to community health groups and hospital boards for district hospitals.[130] HFCs can perform two sets of activities to improve the provision of health services. The first is to support the functioning of health facilities and the objectives of health providers. This can be done by lobbying healthcare providers to engage in community outreach, the co-management of health center resources, and the facilitation of repairs and fundraising. Secondly, HFCs ensure the integration of the citizens and the community preferences in decision-making and service delivery.[131] Most HFCs facilitate social accountability by engaging with healthcare providers in person or through meetings to discuss service failures, leading to changes in the quality of services, such as improved healthcare worker presence, the availability of night shifts, the display of drug prices, and replacement of poorly functioning healthcare workers. Social accountability practices are however often individualized and not systematic, and their success depends on HFCs' leadership and synergy with other community structures.[132]

Social accountability mechanisms and tools can contribute to improved governance, increased development effectiveness through better service delivery, and empowerment. In addition, social accountability enhances awareness, understanding, and appreciation among communities; invokes participatory decision making between rights holders & service providers; promotes shared responsibility; tracks resources, allocation and their utilization; promotes ownership and leadership by communities in development of their communities; helps service providers understand community needs better and promotes understanding of community perceptions on quality and timeliness of services.

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[128] Team. (2018, October 30). How Open Data Fosters Government Accountability. Opendatasoft. https://www.opendatasoft.com/en/blog/how-open-data-fosters-government-accountability/
ten

[129] McCoy, D. C., Hall, J. A., & Ridge, M. (2012). A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. Health Policy and Planning, 27(6), 449–466. https://doi.org/10.1093/heapol/czr077

[130] Molyneux, S., Atela, M., Angwenyi, V., & Goodman, C. (2012). Community accountability at peripheral health facilities: A review of the empirical literature and development of a conceptual framework. Health Policy and Planning, 27(7), 541–554. https://doi.org/10.1093/heapol/czr083

[131] McCoy, D. C., Hall, J. A., & Ridge, M. (2012). A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. Health Policy and Planning, 27(6), 449–466. https://doi.org/10.1093/heapol/czr077

[132] George, A., Scott, K., Garimella, S., Mondal, S., Ved, R., & Sheikh, K. (2015). Anchoring contextual analysis in health policy and systems research: A narrative review of contextual factors influencing health committees in low- and middle-income countries. Social Science & Medicine, 133, 159–167. https://doi.org/10.1016/j.socscimed.2015.03.049

7.3 Equity and inclusion in social accountability processes

Social accountability interventions are undertaken in the context of social structures, multiple strata of power, power dynamics and accountability relations within the health system and society in general, which may serve to diminish or exclude certain voices in society.[133] The health system is a social institution, reflecting these political and social dynamics characterizing the society at large.[134] While sometimes the prevailing social and political structures might work to improve the health and welfare of the most vulnerable and marginalized in society such as women, persons with disabilities, adolescent girls, young people, and other historically marginalized groups, most often they do not.

The National Adolescent Sexual and Reproductive Health Policy, 2015 defines marginalised and vulnerable adolescents as those at high risk of lacking adequate care and protection including: orphans and street children; adolescents with disabilities; adolescents living with HIV and AIDS; adolescents living in informal settlements; adolescents in the labour market; adolescents who are sexually exploited; adolescents living below poverty line and children affected by disaster, civil unrest or war as well as those living as refugees. Not only do such individuals and groups encounter social discrimination and stigma but they also face constrained access to basic needs, including education, health and jobs. Discrimination and stigma force many into isolation: they are seldom represented in civic and public spaces, making them invisible to policymakers. This means their voices are not heard, and their issues not addressed.[135]

Marginalised and vulnerable adolescents generally face severe socio-cultural, economic and structural barriers to accessing SRH information and services. SRH information, education and communication materials are often not translated to formats appropriate for adolescents and youth with disabilities, are not linguistic sensitive, dissemination channels are gender and age blind and do not consider those in dispersed settings and illiteracy, and healthcare providers are not equipped with the skills to offer services to diverse groups adolescents based evolving capacities and age, and less prepared to deal with those with disabilities. The primary purpose of social accountability mechanisms and processes is therefore to enhance the ability of citizens and communities especially the vulnerable, marginalized and disadvantaged in society such as women, youth, elderly, children and persons with disabilities to make their voices heard. Social accountability initiatives thus often target those public sectors of greatest importance to the vulnerable in society and where there is great potential to draw attention to their needs.[136]

Despite one of the objectives of social accountability being to enhance and make the voices of the vulnerable and marginalized to be heard, studies have shown that challenges in ensuring inclusion and equity in social accountability efforts are shaped by the politicization, social

[133] George A. Using accountability to improve reproductive health care. *Reprod Health Matters.* 2003;11:161–170. doi: 10.1016/S0968-8080(03)02164-5.
[134] Bennett S, Ekirapa-Kiracho E, Mahmood SS, Paina L, Peters DH. Strengthening social accountability in ways that build inclusion, institutionalization and scale: reflections on FHS experience. Int J Equity Health. 2020;19:1–6. doi: 10.1186/s12939-020-01341-x
[135] Monyrath Nuth (2022) Improving inclusion through social accountability: Cambodia's experience, World Bank Blogs, East Asia and Pacific on the Rise, May 16, 2022
[136] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

traditions, and stigma attached to, for example, SRHR matters.[137] Values, norms, and judgements related to issues such as single motherhood, sexuality, and fertility may influence provider and policy-maker attitudes regarding key SRHR issues, as well as the quality of care provided.[138]

Deliberative social accountability processes are also sometimes dominated by members of the community who have the most power thereby marginalizing especially vulnerable and marginalized groups – who often may face significant risk and repercussions in speaking out.[139] In addition, vulnerable and marginalized individuals may be unwilling to articulate their concerns in contexts where collective action among particular groups is unsafe and responsiveness by the state is unlikely.[140] For example, a study in Kibuku District–Uganda found that recently pregnant adolescents were unlikely to participate in or benefit from the community scorecard project because of a number of reasons including: stigmatizing and rude treatment by health providers; inconveniently timed meetings; the adolescents feeling uncomfortable discussing their own pregnancy; and the priorities arising from community meetings not including their particular challenges.[141] These findings point to the failure of some social accountability programs to take into account social and power dynamics to support engagement from community members who feel unsafe or unable to speak.[142] As a result, the priorities identified may not reflect the needs or priorities of those who are the most harmed by the status quo.[143]

Other common challenges in social accountability programs relating SRHR, include financing and budgetary constraints; risk of social and physical harm perpetrated by household members, community members, or health system actors; inability to meaningfully address issues that are perceived to be beyond the authority of the program participants; stigma and harmful gender norms among providers and communities; and lack of clear guidance, authority, and knowledge of SRH entitlements at local level. There is also the general lack of programmatic evidence base on if, when, and how social accountability strategies can be used to promote access to quality sexual and reproductive health (SRH) care for stigmatized populations and/or stigmatized issues.[144] To ensure social accountability efforts are inclusive

[137] Boydell V, Schaaf M, George A, Brinkerhoff DW, Van Belle S, Khosla R. Building a transformative agenda for accountability in SRH: lessons learned from SRH and accountability literatures. Sex Reprod Health Matters. 2019;27:64–75. doi: 10.1080/26410397.2019.1622357.

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[139] Dasgupta J. Ten years of negotiating rights around maternal health in Uttar Pradesh, India. BMC Int Health Hum Rights. 2011; 11:1–1. doi: 10.1186/1472-698X-11-S3-S4.

[140] Dasgupta J. Ten years of negotiating rights around maternal health in Uttar Pradesh, India. BMC Int Health Hum Rights. 201; 11:1–1. doi: 10.1186/1472-698X-11-S3-S4.

[141] Apolot RR, Tetui M, Nyachwo EB, Waldman L, Morgan R, Aanyu C, Mutebi A, Kiwanuka SN, Ekirapa E. Maternal Health challenges experienced by adolescents; could community score cards address them? A case study of Kibuku District–Uganda. Int J Equity Health. 2020;19:1–2. doi: 10.1186/s12939-020-01267-4.

[142] Bennett S, Ekirapa-Kiracho E, Mahmood SS, Paina L, Peters DH. Strengthening social accountability in ways that build inclusion, institutionalization and scale: reflections on FHS experience. Int J Equity Health, 2020;19:1–6.

[143] Carmen Malena, Reiner Forster and Janmejay Singh (2004), Social Accountability: An Introduction to the Concept and Emerging Practice, World Bank Social Development Papers, Participation and Civic Engagement, Paper No. 76 December 2004.

[144] Marta Schaaf, Grady Arnott, Kudzai Meda Chilufya, Renu Khanna, Ram Chandra Khanal, Tanvi Monga, Charles Otema, and Christina Wegs (2022), Social accountability as a strategy to promote sexual and

both in terms of populations and issues addressed, programs need to address stigmatize and discrimination issues and advocate for enabling legal framework. Inclusion should also be built into the program design, permeating all stages of implementation.[145]

7.4 **Factors and Dynamics in social accountability in the context of SRH**R

The success of a social accountability process encompasses more than directly measurable health-related outcomes and includes a wider range of governance outcomes such as empowerment, participation, and the responsiveness of duty-bearers.[146] Critical factors of success include access to and effective use of information, civil society and state capacities and synergy between the two.[147] However, evaluating the success of a social accountability process could be methodologically challenging especially with regards to defining the boundaries of interventions and outcomes of interest and the appropriate evaluation design and methodological approach. According to Joshi (2017), the expanding number of outcomes related to social accountability "are expected to unfold, and range from immediate short-term improvements in public services, to more durable long-term changes in states and societies."[148] It is also notable that for the social accountability mechanisms and tools to be effective on the long run, they need to be institutionalized and linked to existing governance structures and service delivery systems.[149]

In the context of sexual and reproductive health and rights, there are a variety of factors and dynamics that affect or impact how social accountability and community participation for young girls and women are exercised. These include the following:

Gender norms around participation: It is important to consider the design of the participatory processes upon which initiatives like public awareness meetings or campaigns, committees among other social gatherings rely to operate. Gender norms that restrict women from access and mobility to public gatherings and women's obligation to perform their chores at home can cause women not to engage as fully in the initiatives.

Citizen engagement in governance: This implies the involvement of citizens in policy-making activities, and budget planning among other government projects to provide the people with the opportunity to evaluate and monitor public decisions and processes. Better outcomes are expected for social accountability when the government involves its citizens in governance

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and therefore makes it possible to enforce the necessary changes in society that will see all young women in the geographical area benefit from the initiative.

Education and Awareness: Low or lack of people's knowledge about reproduction and sexual rights limits them from speaking out freely to communicate their concerns about sexual and reproductive health. This can hinder initiatives' data collection, engagement as well as sensitization. Many communities in rural areas consider discussion on sexual and reproductive health matters embarrassing and not easy to share. A more empowered community has a better chance of indulging in sexual and reproductive health initiatives that encourage and support the sexual well-being of young girls and women.

Cultural Awareness: It is advisable to be aware of the existing cultures and traditions of the community before engaging in an initiative. The views a society holds about sexual and reproductive health rights may affect the reception of new methods or techniques. Societies that are open to learning about other cultures and belief systems help to examine their traditions and how it has influenced their judgment and prejudice about sexual health.

Availability of information and services: The community should be aware of the available services to them, have access, and have receptive channels for any queries or concerns on healthcare including sexual and reproductive health care services. This ensures that the services are speedy, and of good quality. This then results in trust between the health system and the girls and women and generates appropriate responses from the health system in meeting the demands of the girls and young women.

Gender equality and Empowerment: Addressing issues like gender-based violence, limited job opportunities for women, sexual harassment, and early marriage among others helps to boost Sexual and reproductive health and rights. Eradication of harmful activities towards women is crucial in encouraging the community to embrace and protect women's rights.

Reduction of stigma: Values and judgments related to issues like single motherhood and sexuality may influence provider attitudes regarding vital SRHR issues as well as the quality of care provided. Communities that are open to receiving information about the negative effects of stigmatization of sexual rights are likely to see higher success levels in social accountability. Stigma reduction has seen the success of HIV prevention among young women since they can openly talk, and are also confident in getting tested, receiving treatment, disclosing their status, and engaging in safe sex.

While there is a significant improvement in the use social accountability and community participation approaches and tools in addressing sexual and reproductive health and rights issues, there is still work to be done. More sensitizations should be done especially in the rural areas where the cultural practices and traditions still deter these rights from implementation. Stigmatization is also a vital area to be focused on to ensure all young girls and women feel free and supported to access the services available to them at the health centers. This can be done by establishing training programs for health workers to stress non-biased service delivery. To reach out to a large population, collaboration with, the government and different sectors like education and social services will help with more deeply rooted SRHR support and thus better results.

It would be highly recommended that there be the establishment of comprehensive sex education programs to facilitate the community with the relevant information they need about sexual health and therefore assist in the agendas of SRHR. Peer education would further encourage adolescent girls and young women to share and open up with their peers and not to isolate themselves when they need assistance regarding their sexual and reproductive health. Non- governmental organizations that work with young people should also employ social media as a tool to spread awareness about sexual health. Lastly, given the high rates of depression and suicide among adolescents, mental health support should be facilitated to equip young women with the confidence to face their day-to-day challenges in sexual health.

7.5 Barriers to social accountability in the context of AGYW

In sub-Saharan Africa, concerns have been raised regarding the quality of healthcare including sexual and reproductive healthcare services delivered and their outcomes.[150] Existing healthcare system bottlenecks such as drug shortages, disrespect of patients in public healthcare facilities, and healthcare workers' focus on donor-funded activities are among the factors that affect healthcare service functioning in sub-Saharan African countries.[151] Other barriers include:

Cultural norms: This restricts AGYW on the freedom of expression or participation in the decision-making process.

Inadequate representation of AGYW: There is almost zero representation of adolescent girls in decision making therefore limiting their participation social accountability processes.

Power imbalances: AGYW fear speaking up due to repercussions or lack of support which in turn make them shy away from holding their leaders accountable.

Stigma and discrimination: Certain groups of AGYW such as the marginalized and underprivileged communities are discriminated against when making decisions on matters where accountability is concerned. The AGYW face stigmatization in cases where they, for example, lack sanitary pads.

Limited access to education and information: This restricts AGYW from knowing and claiming their rights.

Economic constraints: This is a big challenge that faces AGYW which does not allow them to engage in advocacy or access platforms through which they can hold their leaders accountable for example, accessing media in an expensive affair.

Limited access to technology or digital platforms: The AGYW especially in rural areas have difficulties in accessing digital platforms like the use of smartphones, computers, and reliable internet services.

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Institutional mechanisms: There is either inadequate or lack of enabling institutional mechanisms for meaningful engagement and participation of AGYW in social accountability processes.

Security and safety: AGYW face many security and safety challenges which hinder them from reaching their full potential and participating in social accountability mechanisms.

7.6 Social accountability lessons in the context of AGYW Sexual and Reproductive Health

From the foregoing, some lessons have emerged on social accountability initiatives in the context of AGYW SRHR:

a) That improved knowledge and attitude change among adolescent girls and young women on sexual and reproductive health and rights aspects leads, for example, to consistent use of contraceptive methods, access to HIV testing and counseling, condom use, and utilization SRHR services.
b) That community engagement or involvement in SRHR program and intervention development, and building upon the will of AGYW through co-creation activities, community dialogues, public participation, training, mentorship, etc. contribute to effectiveness of SRHR interventions including HIV and GBV preventive efforts.
c) That creating awareness of the legal and structural issues affecting access to sexual and reproductive justice among the AGYW is critical for success of social accountability initiatives. This includes increasing understanding of the linkages between sexual and reproductive health and rights amongst AGYW and other rights including property rights, child rights and women rights. For example, use of medico-legal clinics will address the common forms of violence and social injustices that affect AGYW by breaking barriers to access medical and legal services.
d) That focused persuasive action to meet the sexual and reproductive health rights needs of the vulnerable AGYW is critical for steady expansion of access to services depending on needs.
e) That developing a more structured model for training AGYW as role models, Ambassadors, Mentors, etc. and putting in place referral mechanisms for access to justice and reporting such as working with community health promoters (CHPs), male champions, widow champions, AGYW champions, and pro bono lawyer networks facilitate access to SRHR and property rights.