



GENDER & COVID-19 STUDY: KEY RESULTS

September 2021

Why This Matters

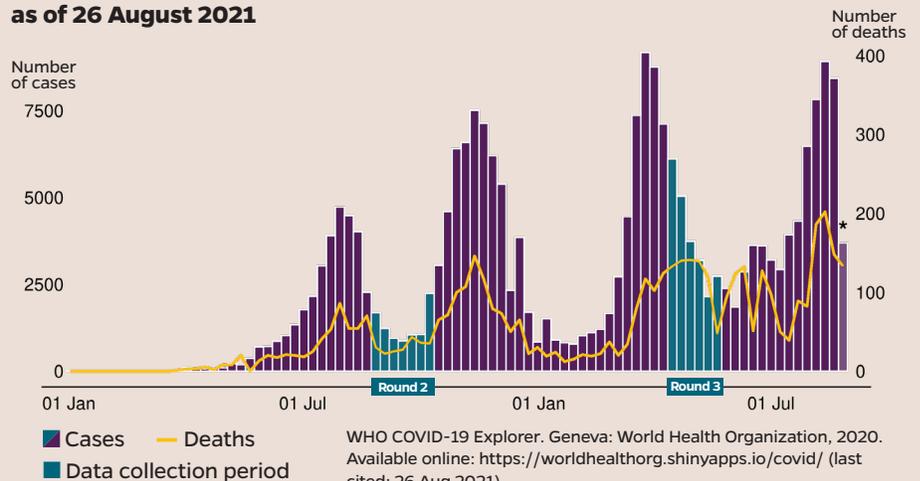
- The COVID-19 pandemic and associated restrictions have created major disruptions to daily life, including healthcare access, ability to generate income, and ability to continue schooling.
- Urban adolescents and young people are uniquely impacted by the COVID-19 pandemic and remain an important group for sexual and reproductive health (SRH).
- Pandemics and other public health emergencies can amplify gender-related barriers to health and well-being.

This brief covers select results from Round 2 and Round 3 of the PMA Youth Respondent-Driven Sampling & Gender/COVID-19 Study. Data for Round 2 was collected in August-October 2020 and data for Round 3 was collected in April-May 2021 with the same cohort of young people aged 16-26 years.

Spotlight on Gender Analysis

A gender analysis includes gender-stratified quantitative analysis and attention to gendered social and economic power dynamics, norms, and underlying inequities. Gender analysis generates the evidence necessary to guide gender-responsive and gender-transformative policy and programming.

Figure 1. Number of COVID-19 cases and deaths by week in Kenya, as of 26 August 2021



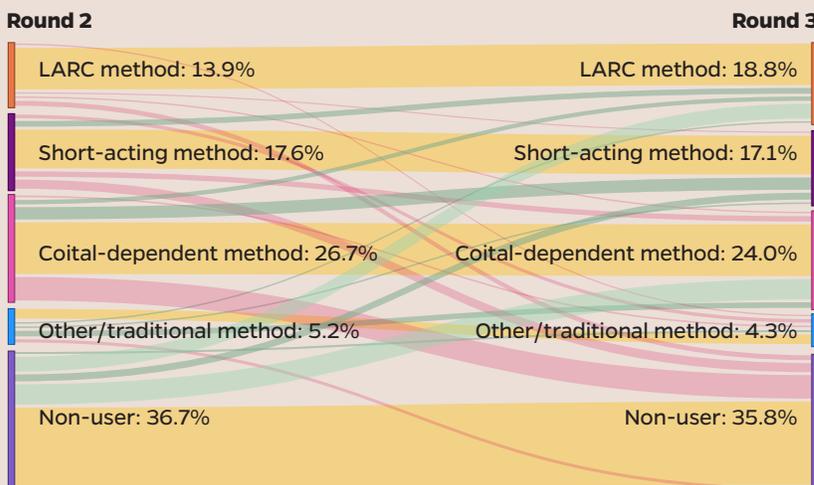
Key Results: Sexual and Reproductive Healthcare

Contraceptive Dynamics & Method Mix

- At the Round 2 follow-up interview, 27.4% of respondents¹ were still using the method reported one year before, 14.4% had switched methods, and 15.3% had stopped using a method. In addition, 27.9% of respondents began using a method and 15.0% remained non-users.
- 69.8% of respondents reported using any contraceptive method at Round 2 and 65.5% reported using any contraceptive method at Round 3.

- At the Round 3 follow-up interview, 38.6% of respondents¹ were still using the method reported in Round 2, 12.5% had switched methods, and 14.0% had stopped using a method. In addition, 14.1% of respondents began using a method and 20.8% remained non-users.
- Male users were heavily reliant on coital-dependent methods, primarily male condoms, at both data collection rounds, while female users reported a broader method mix (Figure 2).

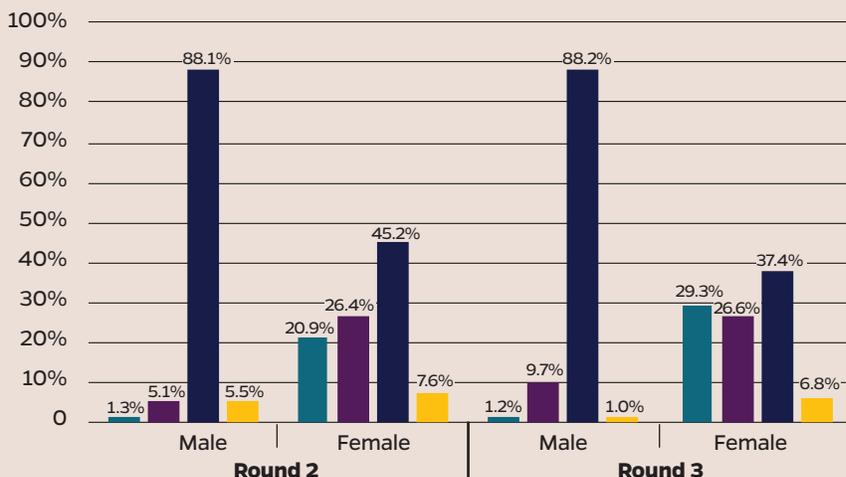
Figure 2. Changes in contraceptive use status from Round 2 to Round 3, among young women (n=414, Round 2; n=393, Round 3)



Coital-dependent methods, like condoms, emergency contraception, and withdrawal were the most common primary method among both young men and youth women at both data collection rounds (Figure 3). Use of long-acting reversible contraception (LARC) increased by nearly 10 percentage points between Round 2 and Round 3 among female users.

■ LARC ■ Short-acting
■ Coital-dependent ■ Other/traditional

Figure 3. Method mix among contraceptive users, by gender and data collection round (n=606 overall, Round 2; n=543 overall, Round 3)



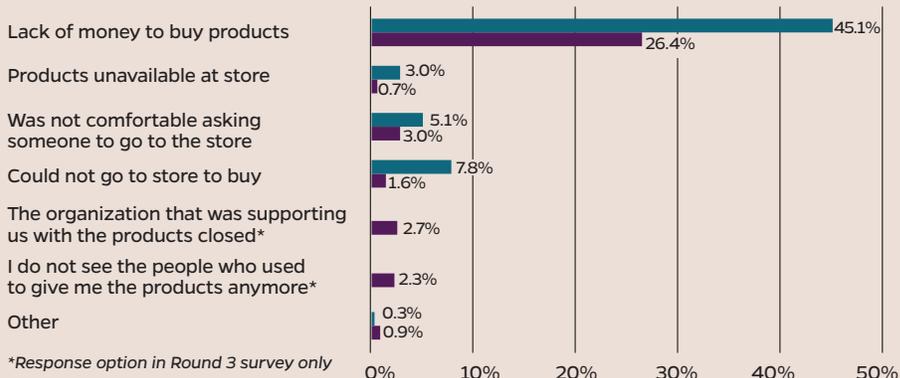
LARC: implant and IUD; Short-acting: injectables and oral contraceptive pills; Coital-dependent: emergency contraception, male condoms, female condoms, withdrawal; Other/traditional: standard days, cycle beads, LAM, herbal pills, other

Menstrual Hygiene Management

In Round 2, over half of young women reported disruptions to accessing menstrual hygiene products since the start of COVID-19 restrictions (52%). Fewer young women reported disruptions to accessing menstrual hygiene products in Round 3: 30.3% overall. Barriers to access are detailed in Figure 4.

■ Round 2
■ Round 3

Figure 4. Barriers to accessing menstrual hygiene products, among young women (n=612, Round 2; n=591, Round 3)



Community Response

In Round 3, respondents were mixed on how their community was responding to the pandemic and mitigation measures. Overall, respondents reported that most people in their community found the governmental guidelines easy to follow (59.6% very or somewhat true) and that people are taking care to protect themselves and others (64.8% very or somewhat true). However, the plurality of respondents reported that it was not very true or not true at all that community members are practicing social distancing guidelines (35.8% and 18.6%, respectively), with about one-third reporting that this was somewhat or very true. Mask wearing was found to be more common (44.3% very or somewhat true).

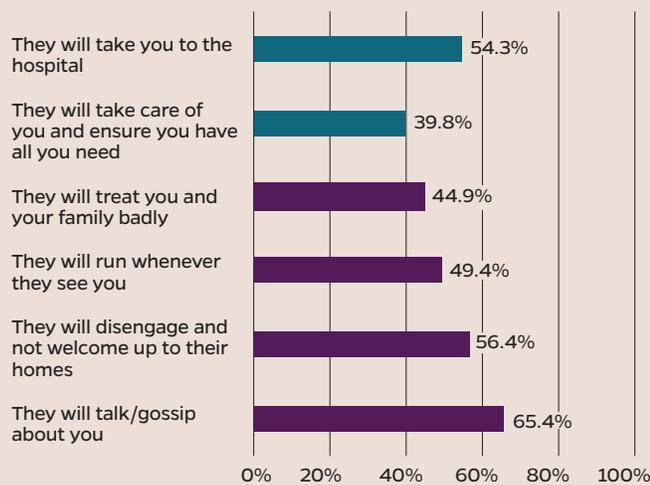
“ I have heard [the] vaccine is being rolled out... Let us say, here in the community [the vaccine is] not easy to get... People in the community have been marginalized a lot... It is very hard for people from down here to go to the centers where the vaccine is being provided... So we have to spread that information up to households in the grass roots. ”

- 20-year-old female IDI participant

Anticipated Stigma

Anticipated stigma from community members was high among respondents: over 60% reported that community members would gossip or talk about you if they knew or suspected that you had COVID-19 (Figure 5). However, over half reported that community members would engage in a positive behavior—taking you to the hospital if needed.

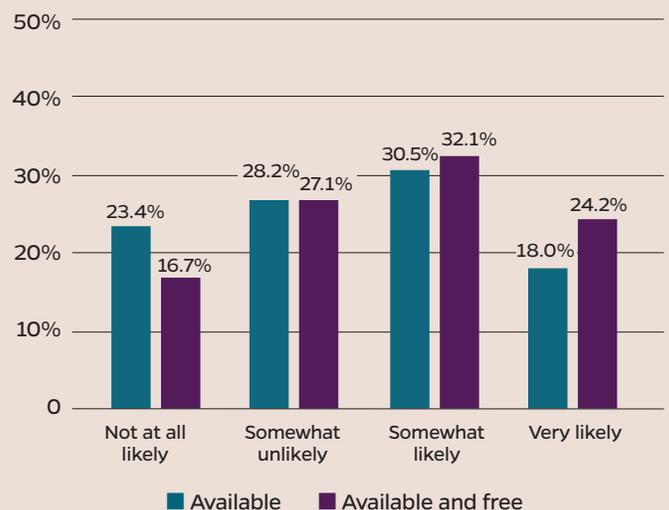
Figure 5. Anticipated community responses to suspected or confirmed COVID-19 cases,² among all Round 3 respondents (n=1177)



Vaccine Acceptance

Less than half of respondents reported that youth would be somewhat likely (30.5%) or very likely (18.0%) to get the COVID-19 vaccine if it became available in Kenya (Figure 6). These proportions increased slightly when respondents were asked if youth would get the vaccine if the vaccine was free. (32.1% somewhat likely, 24.2% very likely)

Figure 6. Likelihood youth in Nairobi will get the COVID-19 vaccine, among all Round 3 respondents (n=1177)



Key Results: Mental Health During the COVID-19 Pandemic

Depressive Symptoms

In both survey rounds, respondents were asked about depressive symptoms experienced in the previous two weeks. From Round 2 to Round 3, reported depressive symptoms decreased for both young men and young women (Table 1). However, qualitative interviews showed continued mental health stressors for young people during the pandemic.

Table 1. Probable depression, by gender and data collection round

Probable depression*	Round 2 (n=1217)		Round 3 (n=1177)	
	Young men	Young women	Young men	Young women
	21.8%	24.3%	14.9%	19.6%

*Probable depression (<2/>3) is a dichotomized indicator based on symptom severity scores from PHQ-2 instrument. The PHQ-2, or Patient Health Questionnaire-2, is a brief (two item) screening tool for depression. The PHQ-2 assesses the frequency of core depression symptoms over the past 2 weeks.

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

Sources of Social Support

- In Round 2, 88.5% of respondents strongly agreed or mostly agreed that they had someone they could “share [their] joys and sorrows with.” In addition, 86.5% strongly agreed or mostly agreed that they had someone “to count on when things go wrong.”
- Mothers and friends were the most reported sources of social support in both survey rounds.

Key Results: Educational and Economic Impact

School Status

Of the 539 students at Round 2 and Round 3 (281 young men and 258 young women), 56.2% of young men and 52.1% of young women reported that they went back to school fully in-person at the time of Round 3 data collection, 11.3% of both young men and young women were continuing online school, and 13.9% of young men and 7.5% of young women were attending both in-person and online. A higher proportion of young women did not return to school at Round 3 compared to young men (20.0% to 11.1%), most commonly because parents did not have money to pay school fees (33.6% among young men and 45.9% among young women) or because the respondent graduated (46.6% among young men and 36.0% among young women).

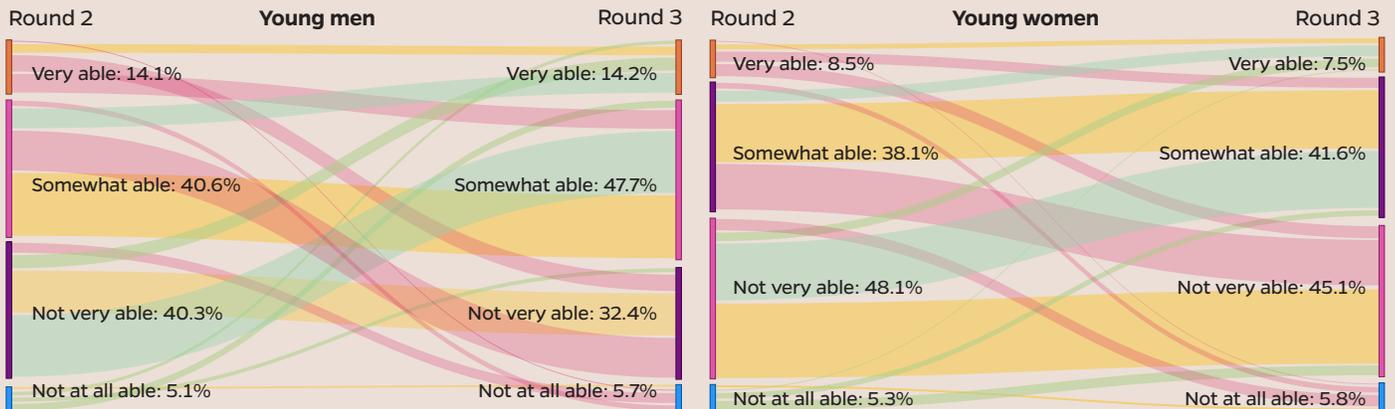
“ Because now the... jobs have reduced. There is no money. Right now... let us say per day a hairdresser can plait one person and she has a family and you want to go to school... Now you see, even when you go to school, you are chased away due to school fees. ”
- 18-year-old female IDI participant

Key Results: Mental Health During the COVID-19 Pandemic

Ability to Meet Basic Needs

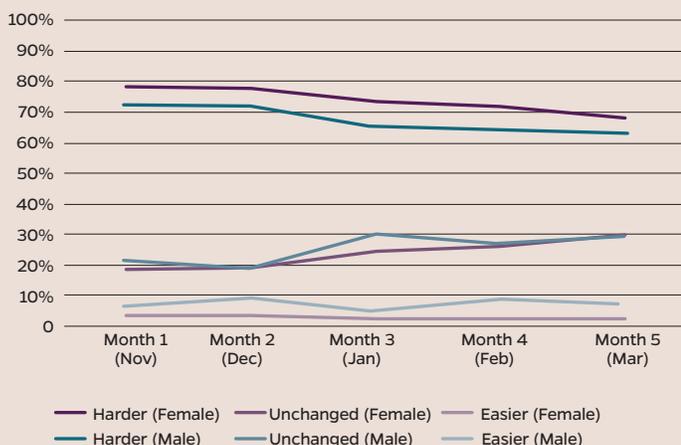
Respondents' ability to meet basic needs only improved slightly between survey rounds (Figure 7) and young women were significantly more likely to report not being able to meet basic needs in both rounds ($p < 0.01$).

Figure 7. Changes in ability to meet basic needs from Round 2 to Round 3, among young men (n=586) and young women (n=591)



Between survey rounds, respondents were invited to submit a monthly mini-survey via text message, which included one question on ability to meet basic needs in the prior month. Both young women and young men were less likely over time to report that it had become “harder” to meet basic needs in the month prior (Figure 8).

Figure 8. Changes in ability to meet basic needs in the prior month by gender, among mini-survey respondents (n=1032, monthly average)



Key Results: Safety & Violence

- Feelings of physical safety in public increased from Round 2 to Round 3 among both young men and young women: only 34.4% of men and 25.6% of women felt very or somewhat safe in Round 2, rising to 52.9% of men and 51.0% of women in Round 3.
- In both Rounds 2 and 3, a similar proportion of partnered young women reported an experience of physical intimate partner violence (IPV): 13.5% in Round 2 and 13.6% in Round 3.

“ [Partner violence] is fueled by drunkenness... At the household, financial issues, lack of money contributes to it [violence]... Because maybe you want food but the partner does not have money! So he ends up getting upset, you do not understand him, [and] you start quarreling. - 23-year-old female IDI participant ”

Key Takeaways

- **Access to contraception remains essential for youth.**
 - Current evidence of increased LARC uptake is promising.
 - The fluidity between non-use and use of coital-dependent methods during the pandemic may reflect changes in access to these types of methods.
- **Youth represent a critical population for overcoming COVID-19-related stigma and ensuring trust to support full vaccine uptake as it becomes available.**
- **The social and economic disruption of COVID-19 remains evident for youth, despite improvements in some domains like mental health and access to menstrual hygiene products.**
 - Youth, and particularly young women, reported sustained challenges in ability to meet basic needs.
- Concerning gender differences were identified in patterns of returning to school, with young women more likely to forgo a return due to gaps in school fees.
- **Supports are needed to ensure overall economic viability, and gender equity in both economic stability and access to education.**
- **The COVID-19 pandemic exacerbated gender-based violence for some youth, with young women reporting persistent rates of intimate partner violence.**
 - Low help-seeking among those affected calls for continued investment in violence support services.
- **Gender-disaggregated data are essential to monitor progress towards gender equality.**

Methods

In 2019, Performance Monitoring for Action (PMA) Agile carried out a Youth Respondent-Driven Sampling Survey (YRDSS) among adolescents and youth ages 15-24 (N=1357, male N=690 and female N=664) in Nairobi, Kenya between June and August (Round 1). In 2020, a fully remote follow-up study (Round 2) was conducted with the study cohort (now ages 16-26) to track changes in contraceptive dynamics and assess the gendered impact of COVID-19. The quantitative surveys were conducted by phone in two distinct sessions to limit participant burden: YRDSS Follow-up (N=1223, male N=610 and female N=613) and Gender/COVID-19 Survey (N=1217, male N=605 and female N=612). Sampling weights accommodate the RDS study design, post-estimation adjustment and non-response adjustment. Virtual qualitative methods included focus group discussions (FGDs) with unmarried youth

ages 15-24 (N=64, over 8 groups), FGDs with youth-serving stakeholders (N=32, over 4 groups), and key informant interviews with higher-level stakeholders (N=12). In-depth interviews were conducted with 20 cohort participants (male N=10 and female N=10). Data collection was conducted from August to October 2020.

In 2021, a second remote follow-up study was conducted with the study cohort (Round 3). One quantitative survey was conducted by phone (N=1177, male N=586 and female N=591). In-depth interviews were conducted with an additional 20 cohort participants (male N=10 and female N=10). Data collection was conducted from April to June 2021.

Additional information and Round 2 results briefs can be found on the PMA website, <https://www.pmadata.org/technical-areas/gender>.

Suggested Citation

PMA Agile/Gender & ICRHK. Gender & COVID-19 Study: Key Results Brief. 2021. Baltimore, Maryland, USA & Nairobi, Kenya: Bill & Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins University Bloomberg School of Public Health & International Centre for Reproductive Health Kenya.

¹The analytic sample for “Contraceptive Dynamics & Method Mix” has been limited to respondents who are sexually active and in need of contraception at both the time of that survey and the prior survey round (N=854 in Round 2; N=814 in Round 3). Respondents who were not sexually active at the time of that survey, who wanted to become pregnant within a year at that survey or at the time of previous interview, and female respondents who were pregnant at that survey or at the time of previous interview are excluded from this analysis, as their contraception needs would have been low or nonexistent.

²Responses to question: “If you tested positive for COVID-19 today or if people in your community suspected that you have COVID-19, how do you think they will treat you?” Multiple responses could be selected.