

Original Research Article

Role of community champions in promoting inclusion of adolescents and young persons in family planning services: a quasi-experimental endline evaluation

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ABSTRACT

Background: Adolescents and young people (AYPs) face disproportionate barriers to family planning (FP), especially in conservative and underserved contexts. This study assessed the role of community champions in improving FP knowledge, attitudes and utilization among AYPs aged 15–24 in Garissa and Tana River Counties, Kenya, under the DEESIP project.

Methods: A quasi-experimental, mixed-methods design evaluated 673 AYPs, using surveys, interviews and focus groups.

Results: Overall, 74% reported FP awareness, higher in Tana River (61%) than Garissa (39%) ($p < 0.001$). Attitudes toward FP were generally positive with youth in intervention areas reporting higher attitudes than controls. Utilization was greater in Tana River (76%) than Garissa (24%) ($p < 0.001$). Exposure to champions significantly increased uptake ($OR \approx 35$, $p < 0.001$), particularly with religious leader engagement.

Conclusions: Champions reduced stigma and provider bias but faced sustainability challenges. Strengthening peer-led and faith-informed strategies is vital for equitable FP access among AYPs in marginalized settings.

Keywords: Adolescents and young people, Contraceptive utilization, Community champions, Family planning, Religious leaders

INTRODUCTION

Access to family planning (FP) is a foundational component of SRHR, yet AYPs aged 10–24 continue to experience disproportionate barriers in accessing these services globally. Despite recognition of FP's role in reducing maternal mortality, promoting gender equality and improving educational and economic outcomes, millions of AYPs especially those in conservative, rural

or underserved settings face sociocultural, structural and informational barriers that limit their ability to make autonomous reproductive choices.^{1–3} Globally, nearly 257 million women of reproductive age in low- and middle-income countries have an unmet need for modern contraception, with adolescents accounting for a large share of unintended pregnancies, unsafe abortions and preventable maternal deaths.^{4,5} In sub-Saharan Africa, these challenges are compounded by restrictive gender norms, provider bias, limited comprehensive sexuality

education and under-resourced youth-friendly service models.^{6,7} Adolescent fertility remains among the highest worldwide, particularly where early marriage and patriarchy intersect with poverty and weak health systems.^{8,9} In Kenya, the national adolescent SRHR policy and FP CIP underscore the importance of reaching AYPs with equitable, youth-friendly FP services.^{10,11} Nonetheless, recent data show that AYPs especially in counties such as Garissa and Tana River exhibit low contraceptive use, with persistent fear of stigma, limited method knowledge and few adolescent-centered delivery models.^{12,13} These counties, predominantly Muslim and pastoralist, present unique challenges tied to cultural norms, low education levels, gender roles and inadequate access to youth-responsive healthcare.

In response, global and national FP programming increasingly employs community-led models, particularly the use of community champions local individuals embedded in social and peer networks who provide peer education, facilitate referrals and counter stigma in hard-to-reach or conservative communities.^{14,15} Emerging evidence points to the effectiveness of champions in expanding reach, improving trust and normalizing FP, especially when combined with engagement of religious leaders and digital platforms.^{16,17} However, limited empirical research exists on how these actors influence AYPs' inclusion in FP services, particularly in marginalized Kenyan counties.

This study explores the role of community champions in promoting inclusive access to FP for AYPs in Garissa and Tana River Counties, Kenya. It investigates how these champions influence FP knowledge, attitudes and service utilization among adolescents and young people and assesses the enabling and limiting factors for sustaining their work. Using a quasi-experimental, mixed-methods design within the Deepening Sustainable and Equitable Increases in FP (DEESIP) project framework, this study offers a timely contribution to evidence on youth-responsive FP programming in culturally complex environments.

METHODS

Study design

This study employed a mixed-methods, quasi-experimental design to assess the impact of youth-champions on FP knowledge, attitudes and uptake among AYP aged 15–24 in Garissa and Tana River Counties. The study was conducted between June and July 2025. Given the study's objective, the participation of youth champions was deemed crucial. Consequently, the champions were selected based on community involvement, leadership potential and commitment to family planning. In addition, community stakeholders, local leaders and youth groups were engaged to nominate youths to participate as champions. Intervention and control sub-counties were pre-selected at project

inception: Garissa and Balambala (intervention) versus Lagdera (control) in Garissa County; and Tana Delta (intervention) versus Tana North (control) in Tana River County. The design facilitated comparative analysis across geographic, demographic and programmatic contexts. Triangulation of data sources, surveys and qualitative data was used to enhance data validity and contextual relevance.

Inclusion and exclusion criteria

Participants included AYPs and community champions who have resided in the selected study sites for at least three years, healthcare workers involved in reproductive health and family planning (FP) service provision and county and sub-county Ministry of Health leaders directly or indirectly involved in FP service delivery. Individuals who did not provide informed consent to participate in the study were excluded.

The intervention

Under the deepening sustainable and equitable increases in FP (DEESIP) Project (2022–2025), Amref Health Africa, in collaboration with the SUPKEM, implemented adolescent-responsive strategies to promote FP among AYP. These included the identification and training of youth champions, who led integration of FP into youth forums, social media mobilization and youth-led drama and theatre initiatives. Champions were trained on rights-based FP messaging, gender sensitivity and adolescent developmental needs and were embedded in community youth networks, schools, madrassas and digital platforms such as WhatsApp and Facebook. In intervention areas, youth champions worked collaboratively with CHPs and religious leaders to create stigma-free referral pathways and facilitate respectful engagement with adolescents. Messaging emphasized informed choice, respectful counseling and youth-friendly service points, while digital channels provided discreet access to FP information.

Study area

The study was conducted in five sub-counties across Garissa and Tana River Counties, selected based on high maternal mortality, low contraceptive prevalence and limited youth-specific SRHR programming. These included Garissa, Balambala and Lagdera in Garissa County and Tana Delta and Tana North in Tana River County. Selection criteria included accessibility, population size, security and presence of AYP intervention activities.

Study tools

Quantitative data were collected using a structured household survey. The tool included modules on FP knowledge, attitudes, use of services, exposure to youth-specific and religious interventions and preferred

information channels (e.g., social media). Data collection was digitized via KoBo Toolbox. Qualitative data were collected using semi-structured KII and IDI targeting youth champions, healthcare workers, religious leaders and policymakers. FGDs were held with male and female AYP, including persons with disabilities, using participatory techniques to probe barriers, enablers and lived experiences related to FP.

Data collection methods

A total of 673 AYP were surveyed, disaggregated by intervention status. Data collection was conducted by trained youth-friendly enumerators in local languages. Real-time uploads via mobile devices enabled prompt quality checks. Qualitative data were collected through 16 FGDs (including youth-only groups), 6 IDIs with youth champions and Muslim scholars and 31 KIIs with stakeholders across both counties. Youth voices were intentionally centered in data collection through peer-led facilitation and age-appropriate approaches.

To ensure data quality, field supervisors conducted random spot-checks and reviewed completed questionnaires daily to verify accuracy, completeness and consistency. Debrief sessions with Research Assistants were also held regularly to address emerging challenges, document lessons learnt, reinforce adherence to study protocols and maintain high data standards across sites.

Sampling

A multistage stratified cluster sampling approach was used for the quantitative AYP survey. Villages were selected using probability proportional to size (PPS), followed by household randomization. All eligible AYPs in selected households were invited to participate. Sampling was proportionally distributed across sub-counties based on 2019 KNBS census projections. The calculated sample size accounted for an expected moderate effect size (MDES=0.24), a 95% confidence level, 80% power and a design effect of 1.2. Qualitative participants were purposively sampled to include a mix of AYP (male/female, in and out of school, with and without disabilities), youth champions and other relevant stakeholders. Selection ensured diversity of experience, geographic spread and intervention exposure.

Data analysis

Quantitative data were analyzed using STATA version 15. Descriptive statistics summarized sociodemographic characteristics and FP indicators among AYP. Chi-square tests assessed associations between categorical variables, while logistic regression models examined the influence of intervention exposure on FP use among AYP, controlling for confounders such as education, marital status and county. Adjusted odds ratios (AORs) and 95% confidence intervals (CIs) were used to report effect sizes. Note that the specific targeting of AYP 15-19 was done

as sub-group analysis, from this wider dataset. Qualitative data were transcribed verbatim and analyzed in NVivo using a thematic framework approach. Themes focused on knowledge sources, service access, stigma, peer support, gender norms and the influence of community actors. Triangulation of data sources ensured analytical rigor and supported validation of youth-specific insights.

Ethical considerations

The study followed ethical principles of informed consent, voluntary participation and confidentiality, particularly given the sensitivity of FP topics among youth. Parental consent and adolescent assent were obtained for participants below 18 years. Ethical approval was granted by the AMREF Health Africa Ethics and scientific review committee and the study was registered with the national commission for science, technology and innovation (NACOSTI).

RESULTS

Sociodemographics

Adolescents and young people sub-sample

A total of 673 AYPs aged 15–24 years were interviewed across both counties. Tana River accounted for 56.3% of this subgroup, while Garissa contributed 43.7%. The AYP population was balanced across the study arms, with 47.1% in the intervention group and 52.9% in the control group. In terms of sub-county distribution, most of the respondents in Garissa were from Garissa Township (60%) and Lagdera (30%), whereas Tana River respondents were mainly from Tana North (71%) and Tana Delta (29%).

The majority of respondents were aged 20–24 years (62%), with slightly higher representation in Garissa (56%) compared to Tana River (66%). Marital status differed significantly, with more single respondents in Garissa (45%) and more married respondents in Tana River (64%). Religion also varied, with Garissa and Tana River both predominantly Muslim (90%) and (71%) respectively. Regarding education, secondary incomplete or complete levels were most common across both counties, though Garissa had slightly higher proportions with no formal schooling (23%) compared to Tana River (15%).

Current use of any method to prevent pregnancy was higher in Tana River (81%) than in Garissa (66%). Occupations were diverse, with many respondents relying on donations or having “other” jobs; Tana River had a higher proportion of small-scale traders (18%) and farmers (4.2%), whereas Garissa had more respondents in “other” occupations (47%) and casual labor (10%). Overall, these findings highlight notable differences in sociodemographic profiles between the two counties that

may influence youth FP uptake. The results are detailed in Table 1.

Knowledge of FP Among AYP

Among AYP Respondents, 74.1% reported awareness of at least one FP method, while 25.5% had no knowledge and 0.4% did not respond. Disaggregation by county further revealed notable disparities: in Tana River, FP knowledge among youth was significantly higher (61.2%) compared to Garissa (38.8%). Qualitative findings reinforce this pattern, indicating that youth in Garissa often lacked access to formal FP information sources. Instead, they relied on peer-to-peer conversations, informal channels or limited exposure through school or religious institutions.

Youth in intervention areas, however, reported more frequent contact with community champions, particularly through virtual platforms such as WhatsApp and Facebook, which offered private and socially acceptable avenues for accessing FP information. Community FGDs highlighted that community champions were embedded within youth networks playing a pivotal role in bridging these knowledge gaps. Reported exposure to FP messages among youth was very low across all channels. Only 2.4% of youth heard FP messages from community health promoters (CHPs), 1.8% from religious leaders, 0.9% from madrasa and 3.2% through drama/theatre.

Qualitative interviews reinforce this information by noting that youths in Garissa and Tana River lack official access to family planning information and instead rely on peer talk, social networks and occasional access through schools or faith places. Open conversation is stunted by stigma and culture, making people struggle to access accurate information.

“Most of the youth in our area don’t get this information (on FP) unless someone brings it to them in school or mosque... and even that is rare.” – Youth FGD, Garissa.
“I only came to know about FP when the community health worker explained it during the group session.” – Female youth, Tana River.

“I mobilize youth using social media and WhatsApp to share information on where they can find friendly services.” – Youth Champion, Garissa.

Dynamics of family planning uptake among youths with disability

KIIs and FGDs revealed that youths with disabilities face inherent risks in accessing and utilizing FP services. The situation is further exacerbated when youths face multiple barriers, including living in remote areas as well as cultural and religious hinderances. The most striking hinderance is displayed by community perspectives, indicating that youth with disability do not require FP services as they are unable to give birth. Besides, not all

youth with disabilities have been registered with social services or have government issued IDs, further limiting access and utilization of care. KIIs noted that registration was a key component in ensuring access to a broad array of services including reproductive health. As such, the study proposed several remedial measures including, constructing ramps and widening doors for wheelchair access, especially in facilities that lacked, training health workers in sign language, providing FP materials in Braille or easy-to-read formats, ensuring that facilities have disability-inclusive staff or peer navigators, establishing private and safe youth-friendly corners and adding visual charts or videos for people with intellectual disabilities. These approaches were noted to increase youth autonomy and agency to seek FP services.

“Health centers should be equipped with ramps and wheelchairs... and people who know sign language.” TN_stakeh_RL.PWD.
“They should push for disability-friendly clinics and youth corners.” TN_FGD_PWDC_1
“The awareness is low... some even don’t know family planning is allowed for them.” TN_FGD_PWDC_1

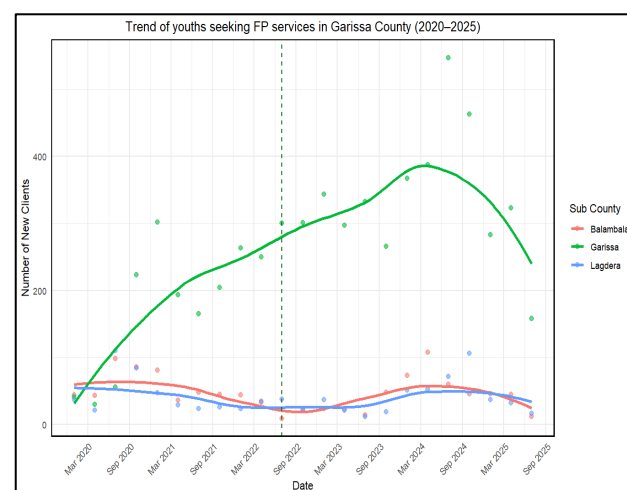


Figure 1: FP uptake for new clients among the youths aged 15-24 years in Garissa County.

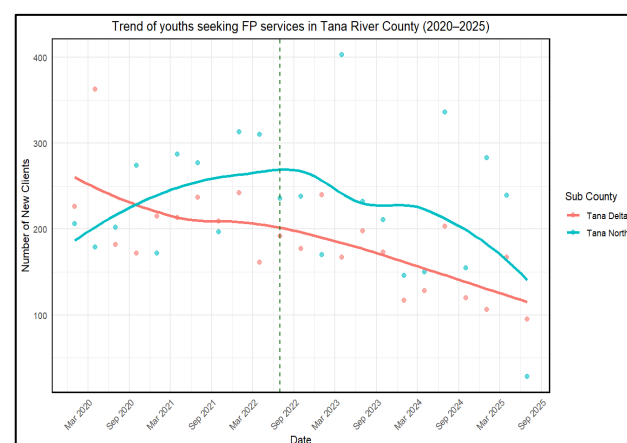


Figure 2: FP uptake for new clients among the youths aged 15-24 years in Tana River County.

Attitudes toward family planning among adolescents and young people

Attitudes toward FP were assessed using a 15-item Likert scale designed to capture perceptions across four domains: partner dynamics, community norms, religious and familial influence and perceived barriers to contraceptive use. To ensure consistency in interpretation, items reflecting negative attitudes or barriers were reverse-coded, such that higher scores uniformly indicated more supportive attitudes toward FP. The scale demonstrated acceptable internal reliability, with a Cronbach's alpha of 0.69, indicating that the items were reasonably cohesive in measuring the underlying construct. The mean attitude scores across for AYP was 3.12 (SD=0.46) on a 5-point scale, suggesting that the overall population held moderate to generally positive attitudes toward FP. This reflects a favourable environment for FP uptake, though continued efforts may be needed to shift deeper cultural and relational norms that influence contraceptive decision-making.

Disaggregated results revealed significant variation by intervention status: youth in intervention areas reported more supportive attitudes (mean=3.31, SD=0.44), compared to their peers in control areas (mean=2.96, SD=0.41; $t=20.13$, $p<0.001$). Regression analysis further confirmed that a one-point increase in positive attitude score was associated with significantly higher likelihood of FP use (Coef=1.27, $p<0.001$). These findings suggest that interventions which foster positive perceptions around FP, particularly those using peer-led, culturally sensitive approaches, are likely to drive behaviour change.

Qualitative narratives echoed this theme, revealing how champions and religious leaders helped counter stigma, address misconceptions and promote youth agency. It indicated that champions employed storytelling and community dialogue to reframe FP as a responsible and respectful choice, even for AYPs. Qualitative findings further indicated that these strategies were particularly effective in shifting the views of community gatekeepers, such as parents and religious figures, who often influence youth behaviour. "Some people still believe persons with disability cannot engage in sex, so they don't think FP applies to them."—FGD, Woman of Reproductive Age, Garissa. "I had to explain to a parent that just because his daughter is disabled doesn't mean she cannot get pregnant."—IDI, Muslim Scholar, Garissa. "Champions reduce stigma in the community. They clarify FP myths during forums and support referrals to facilities."—Stakeholder TWG, Tana River.

FP utilization among AYPs

A total 24% of AYPs in Garissa and 76% in Tana River self-reported to be using FP method. AYPs who reported exposure to Adolescent and Youth Program actors (CHPs, pharmacies, other community figures) had

significantly higher FP use (5.6%) compared to those with no exposure (0.4%) ($p<0.001$). Regression analysis showed that Youth exposed to AYP actors had significantly higher odds (OR≈35X) of using FP compared to non-exposed youth, even after adjusting for county, education and marital status.

This study found that being in the intervention group was positively associated with FP use (Coef=0.56, $p<0.001$). despite this, the interaction term between youth and intervention was not significant (Coef=-0.05, $p=0.824$), suggesting the intervention did not disproportionately benefit youth compared to older age groups.

Qualitative data highlighted that despite relatively high awareness, actual FP utilization among AYP remained considerably low. Logistic regression analysis confirmed that AYPs aged 15–24 was significantly less likely to use FP than older respondents. The odds ratio was 0.59 (95% CI: 0.45–0.78, $p<0.001$), indicating that youth were 41% less likely to report current use of FP, even after adjusting for relevant covariates.

Key Informants further noted that AYP face a wide range of barriers in up taking FP, including fear of judgment, limited youth-friendly service models, cultural taboos and structural inaccessibility. Qualitative data further suggest that where peer support mechanisms, such as community champions, these barriers were partially mitigated. Youth champions were said to facilitate referrals, provide psychosocial support and create safer environments for AYPs to explore their reproductive health needs. These champions were noted as instrumental in normalizing FP for marginalized youth, especially in rural or stigmatized settings. However, these positive observations were primarily observed in intervention areas, where champions received some level of facilitation and training support.

"The youth now say they feel seen. Before they didn't think these services were meant for them." – Youth Champion, Garissa. "The champions even talk to girls during madrassa or school breaks... They know how to approach them in a respectful way." – KII, Tana River Level 4. "I went with her to the hospital because she feared the provider might not understand her condition."—Persons with Disability Champion, Garissa.

Logistic regression analysis revealed that exposure to structured AYP interventions and FP messaging from religious leaders were each significantly associated with higher FP use. AYP exposure had a strong positive effect (Coef=2.62, $p<0.001$), while religious messaging also contributed positively (Coef=0.43, $p<0.001$). The interaction term between the two was dropped due to perfect prediction—indicating that all respondents exposed to both interventions reported FP use - suggesting an exceptionally strong combined effect. Covariates such as higher education, being married and residing in Tana River also significantly predicted greater FP uptake.

These findings highlight the powerful synergistic potential of integrating youth-focused programming with religious leader engagement in FP interventions, especially in culturally conservative contexts.

Comparison of family planning services uptake among the youths (new clients) aged 15-24 years using KHIS data

Garissa county

Between July 2022 and June 2025, the intervention sites demonstrated substantial growth in new clients compared to the control site. In Balambala, new clients increased from 31 in the first half of 2022 to a peak of 181 in the second half of 2024, representing a total gain of 150 clients over the period. Garissa started strong with 601 clients in 2022-H1, peaking at 1,010 in 2024_H1, before declining to 606 in 2025-H2, reflecting an overall gain of 5 clients compared to the starting point but maintaining consistently high numbers throughout.

In contrast, Lagdera, the control site, showed more variability and lower overall growth, with numbers fluctuating from 60 in 2022-H1, peaking at 178 in 2024-H1 and dropping to 69 in 2025-H2. Overall, the interventions in Balambala and Garissa appear to have sustained higher client uptake and more consistent growth than the control, highlighting the positive impact of the program.

Tana river county

In Tana River County, trends in new FP clients varied notably between the two sub-counties. In Tana Delta (Intervention site), the number of new clients started at 369 in the first half of 2022 and remained largely stable through the first half of 2023, with a slight increase to 371 (+0.5%). Numbers then rose modestly to 407 (+9.7%) in the second half of 2023 before declining in 2024, dropping to 323 (-20.6%) in H1 and further to 245 (-24.1%) in H2. By the second half of 2025, uptake partially recovered to 273 (+11.4%), though it remained below the previous peak.

In Tana North (control site), new FP client numbers began higher at 474 in H1 2022 but fell slightly to 443 (-6.5%) in H1 2023. This was followed by a substantial increase to 573 (+29.3%) in H2 2023, marking the highest point during the observation period. However, 2024 saw a marked decline, with numbers dropping to 491 (-14.3%) in H1 and sharply to 296 (-39.7%) in H2, likely reflecting the impact of healthcare worker strikes and service disruptions. By H2 2025, there was a strong rebound to 522 (+76.4%), surpassing pre-2024 levels.

Overall, the trends indicate that while both sub-counties experienced peaks in late 2023, Tana North showed more pronounced fluctuations, with larger drops and

recoveries, whereas Tana Delta exhibited more moderate changes.

Sustainability risks and challenges facing community champions

While community champions have played a transformative role in improving youth access to FP services, the continuation and scale-up of these positive outcomes face significant threats. Champions in both tana river and garissa counties operate under substantial constraints that limit their effectiveness and long-term impact. A primary challenge is the lack of facilitation and transport support, which restricts their ability to conduct outreach in remote or marginalized areas, particularly for adolescents and persons with disabilities who depend on accompaniment and follow-up.

Many champions have not received refresher training since their initial orientation, leaving them ill-equipped to address emerging issues such as youth-friendly service delivery, inclusive communication and rights-based FP messaging. Their contributions also remain under-recognized within formal health systems, where they lack defined roles, proper identification or compensation, factors that undermine their motivation and perceived legitimacy.

Compounding these challenges is the limited availability of inclusive communication tools, such as FP materials in Somali, visual formats for low-literacy populations or audio resources for youth with visual impairments. Without targeted investments to strengthen their operational capacity and institutional integration, the substantial progress made through youth engagement risks stagnation or reversal.

Authors need updates and training on new methods. Don't just push a new injectable and expect us to explain it" (Tana River-KII-HCW). Authors lack FP materials in Somali or audio formats for youth with disabilities. It makes outreach difficult, (Garissa-FGD-PWD Champion).

On the overall, this study notes that FP knowledge and utilization rates among the AYP remain far below those of the general population, largely due to entrenched stigma, poor access to services and a lack of youth-centered delivery models. However, promising gains were observed in areas where community champions and intervention activities were more active, leading to stronger attitudes and improved engagement. To close these gaps, targeted investment in peer-led education, youth-friendly services and inclusive messaging (including via digital platforms) should be prioritized.

Strengthening the role of community champions, particularly those embedded within youth networks, remains a critical strategy for sustainable and equitable FP uptake among adolescents and young people.

Table 1: Sociodemographic characteristics of the participants.

Characteristics	Category	Overall 673 N (%)	Garissa 294 N (%)	Tana river 379 N (%)	P value
Subcounty	Balambala	31 (4.6)	31 (11)	0 (0)	0.001
	Garissa township	175 (26)	175 (60)	0 (0)	
	Lagdera	88 (13)	88 (30)	0 (0)	
	Tana Delta	109 (16)	0 (0)	109 (29)	
	Tana North	270 (40)	0 (0)	270 (71)	
Age group (in years)	15–19	259 (38)	130 (44)	129 (34)	0.007
	20–24	414 (62)	164 (56)	250 (66)	
Presence of disability	No	662 (98)	288 (98)	374 (99)	0.7
	Yes	8 (1.2)	4 (1.4)	4 (1.1)	
	No response	3 (0.4)	2 (0.7)	1 (0.3)	
Marital status	Single	260 (39)	133 (45)	127 (34)	0.011
	Married	394 (59)	152 (52)	242 (64)	
	Divorced	12 (1.8)	5 (1.7)	7 (1.8)	
	Separated	7 (1.0)	4 (1.4)	3 (0.8)	
Religion	Christian	139 (21)	29 (9.9)	110 (29)	<0.001
	Muslim	534 (79)	265 (90)	269 (71)	
Level of education	No formal school	123 (18)	68 (23)	55 (15)	<0.001
	Pre-primary	27 (4.0)	11 (3.7)	16 (4.2)	
	Primary incomplete	98 (15)	29 (9.9)	69 (18)	
	Primary complete	118 (18)	44 (15)	74 (20)	
	Secondary incomplete	146 (22)	61 (21)	85 (22)	
	Secondary complete	127 (19)	58 (20)	69 (18)	
	Post-secondary/College/University	20 (3.0)	9 (3.1)	11 (2.9)	
	Other	14 (2.1)	14 (4.8)	0 (0)	
Current use of any method to avoid pregnancy	Yes	498 (74)	193 (66)	305 (81)	<0.001
	No	171 (25)	98 (33)	73 (19)	
	No response	3 (0.4)	3 (1.0)	0 (0)	
Current main occupation	None/rely on donations	260 (39)	88 (30)	172 (45)	
	Other	214 (32)	138 (47)	76 (20)	
	Small scale trader	85 (13)	16 (5.4)	69 (18)	
	Casual labour	54 (8.0)	30 (10)	24 (6.3)	
	Pastoralist	42 (6.2)	21 (7.1)	21 (5.5)	
	Farmer	17 (2.5)	1 (0.3)	16 (4.2)	
	Permanent job	1 (0.1)	0 (0)	1 (0.3)	

Table 2: Impact of youth exposed to AYP actors on FP use.

Variables	Coefficient	Std. Err	z	P value	95% CI
AYP exposure (exposed)	3.56	0.87	4.09	0.000	(1.85, 5.26)
County (Tana River)	1.12	0.21	5.25	0.000	(0.70, 1.54)
Secondary+education	1.09–2.72	Varies	—	<0.01	Significant
Marital status (Married+)	1.85–2.67	Varies	—	<0.01	Significant

DISCUSSION

This study explored the knowledge, attitudes and utilization of FP among AYP in Garissa and Tana River Counties, with a specific focus on the influence of youth engagement strategies and community-based

interventions. The findings reveal a complex but promising landscape in which targeted interventions, especially those involving community champions and religious leaders, significantly enhance FP awareness, shift attitudes and increase uptake among youth in conservative, underserved settings. Despite three-quarters of AYP respondents reporting awareness of at least one

FP method, significant disparities persist across counties. Youth in Tana River exhibited notably higher levels of FP knowledge compared to those in Garissa, reflecting differences in exposure to structured interventions and information dissemination platforms. The limited presence of formal FP education in Garissa has forced young people to rely heavily on informal sources such as peer conversations, occasional school lessons or religious spaces none of which offer consistent or medically accurate information. The study also points to the growing utility of virtual platforms such as WhatsApp and Facebook for reaching youth with FP messaging in a culturally acceptable manner. Community champions, embedded within peer networks, utilized these platforms to create safe and confidential spaces for learning, resonating with global findings that digital tools can overcome stigma and provider bias in SRH service delivery among youth.^{7,9} Attitudinal data demonstrate that while youth overall hold moderately supportive views toward FP, those in intervention areas where peer-led outreach and religious framing were emphasized exhibited significantly more positive perceptions. These findings align with prior evidence indicating that values-based, culturally adapted messaging is more effective in shifting social norms and increasing acceptance of contraceptive use in conservative settings.^{8,15} Religious and community gatekeepers, when positively engaged, were shown to reduce misinformation and foster a supportive environment for youth to make informed FP choices. Religious scholars cited Qur'anic teachings to validate child spacing, while youth champions facilitated storytelling and respectful dialogues to reframe FP as responsible decision-making rather than taboo. This mirrors global experiences in Muslim-majority contexts, where religious endorsement significantly alters community attitudes.^{17,16}

Although knowledge and attitudes improved in intervention areas, overall FP utilization among AYP remained lower than that of the general population, with stark differences between counties. Tana River youth reported far higher uptake, likely due to broader community engagement and youth-friendly service models. The regression analysis confirmed that exposure to AYP actors including trained community health promoters, pharmacies and youth champions was the strongest predictor of FP use, with exposed youth showing 35 times higher odds of use compared to non-exposed peers. This underscores the importance of tailored outreach and interpersonal communication in promoting contraceptive uptake.¹³ Interestingly, while intervention exposure was positively associated with FP use, the lack of a significant interaction effect for age group suggests that the intervention's impact on AYP was not disproportionately greater than its impact on other demographic groups. This highlights a critical programmatic need to design and scale FP initiatives that are explicitly youth-cantered and responsive to their unique psychosocial and access-related barriers. Qualitative data revealed that beyond information and

attitude shifts, AYP face significant structural and relational barriers to FP access. These include fear of judgment, limited youth-friendly services, gendered norms that silence reproductive autonomy and inaccessibility of facilities especially for youth with disabilities. The presence of trained and supported community champions helped mitigate these constraints by offering accompaniment, psychosocial support and referrals, reaffirming their central role in effective SRH programming.¹ However, champions' impact is hampered by a lack of facilitation, weak institutional recognition, limited access to inclusive materials (e.g., Somali-language or disability-adapted content) and absence of refresher training. Without sustainable investment in these frontline actors, progress made in improving AYP engagement with FP is at risk of stagnation or regression. Strengthening this cadre with logistical, financial and institutional support should be considered a priority strategy for youth-focused SRH scale-up.²

The combined influence of structured AYP interventions and religious messaging emerged as especially potent, with all respondents exposed to both reporting FP use a perfect prediction scenario that signals the synergy of coordinated, multi-stakeholder strategies. Such integrated approaches are increasingly recognized as effective in culturally sensitive and complex environments.^{4,18} Yet, sustainability remains a pressing concern. Champions are often undercompensated and undertrained, while health systems have yet to fully institutionalize youth-responsive models of care. Long-term success will depend on formalizing the role of champions, investing in youth-friendly service points and ensuring culturally relevant communication tools are embedded in local systems. In addition, digital platforms already showing traction among youth should be scaled with safeguards and confidentiality protocols to protect vulnerable users.

Limitations

Several limitations should be considered when interpreting these findings. First, reliance on self-reported data may have introduced social desirability bias, particularly on sensitive issues like contraceptive use and religious influence, potentially affecting accuracy.

Second, the absence of a systematic survey of male respondents limited the ability to fully explore shifting gender norms and male involvement in FP. However, the study mitigated these risks through robust quality assurance measures, including tool pretesting, enumerator training and triangulation of qualitative and quantitative data, which enhanced data credibility and ensured a comprehensive understanding of FP dynamics among adolescents and young people.

CONCLUSION

This study highlights persistent gaps and emerging opportunities in improving FP among AYP in Garissa and

Tana River. While knowledge of FP is moderately high, actual uptake remains low, particularly in Garissa, due to stigma, limited youth-friendly services and socio-cultural barriers. However, youth exposed to community champions and religious leaders demonstrated significantly better knowledge, more positive attitudes and higher FP use. Peer-led outreach, digital platforms and religious framing were especially effective in shifting norms and increasing access.

Community champions played a pivotal role in reducing stigma, facilitating referrals and supporting youth with disabilities. Despite these gains, sustainability challenges such as lack of facilitation, training gaps and weak institutional support limit long-term impact. For sustained progress, FP programs must invest in inclusive, youth-cantered approaches that integrate champions, faith actors and digital tools, while strengthening their operational capacity and embedding them within local health systems.

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REFERENCES

- United nations population fund (UNFPA). Adolescent and youth demographics: Regional overview of challenges and opportunities. New York: UNFPA; 2022. Available from: <https://www.unfpa.org>. Accessed on 21 March 2025.
- World Health Organization. WHO guideline on self-care interventions for health and well-being. Geneva: WHO. 2022. Available at: <https://www.who.int/publications>. Accessed on 21 March 2025.
- Guttmacher Institute. Adolescent sexual and reproductive health in low- and middle-income countries: An overview. New York: Guttmacher Institute; 2020. Available at: <https://www.guttmacher.org/fact-sheet/adolescent>. Accessed on 21 March 2025.
- Bongaarts J. United Nations Department of Economic and Social Affairs, Population Division World Family Planning 2020: Highlights, United Nations Publications. Popu Dev Rev. 2020;46(4):857-8.
- Darroch JE, Woog V, Bankole A, Ashford LS. Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents. New York: Guttmacher Institute; 2016. Available at: <https://www.guttmacher.org/report/adding-it-up-contraceptive-needs-of-adolescents>. Accessed on 12 March 2026.
- Bankole A, Malarcher S. Removing barriers to adolescents' access to contraceptive information and services. Stud Fam Plann. 2010;41(2):117-24.
- Chandra-Mouli V, Lane C, Wong S. What does not work in adolescent sexual and reproductive health: A review of evidence on interventions commonly accepted as best practices. Glob Health Sci Pract. 2015;3(3):333-40.
- Barden-O'Fallon J, Barry MA, Brodish P, Hazerjian J. Gender norms and family planning uptake in developing countries: A systematic review. Stud Fam Plann. 2020;51(1):51-70.
- Marston C, Tabot M. How can we put rights at the core of global family planning. Lancet. 2023;29;401.
- Mutea L, Ontiri S, Kadiri F, Michieleson K, Gichangi P. Access to information and use of adolescent sexual reproductive health services: Qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya. Plos One. 2020;15(11):241985.
- Thomas D, Wanje G, Eastment MC, McClelland RS, Mwaringa E, Patta S, et al. The cost of implementing the Systems Analysis and Improvement Approach for a cluster randomized trial integrating HIV testing into family planning services in Mombasa County, Kenya. BMC Health Serv Res. 2022;22(1):1480.
- Mwaura HM, Kamanu TK, Kulohoma BW. Sub-national disparities in indicators of maternal mortality in Kenya: insights from demographic health surveys towards attaining SDG 3. J Women Health Develop. 2024;7(3):29-40.
- Akseer N, Phillips DE, Exemplars in Global Health Partner Network. Drivers of success in global health outcomes: a content analysis of exemplar studies. PLOS Global Publ Heal. 2024;4(5):3000.
- High-Impact Practices in Family Planning (HIPs). Community group engagement: Changing norms to improve reproductive health. Washington, DC: HIPs. 2020. Available at: <https://www.fphighimpactpractices.org>. Accessed on 21 March 2026.
- Sadore AA, Kebede Y, Birhanu Z. Effectiveness of engaging religious leaders in maternal health education for improving maternal health service utilization in Ethiopia: cluster randomized controlled trial. Front Pub Health. 2024;12:1399472.
- Population Council. Religious leaders and SRHR: Evidence for engaging gatekeepers in Muslim communities. Nairobi: Population Council; 2022. Available at: <https://www.popcouncil.org>. Accessed on 21 August 2025.
- Ahmed S, Li Q, Liu L, Tsui AO. Maternal deaths averted by contraceptive use: An analysis of 172 countries. Lancet Glob Health. 2019;7(3):320-9.
- Hardee K, Jordan S. Advancing rights-based family planning from 2020 to 2030. J Contraception. 2021;9:157-71.

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