



FINAL REPORT

BASELINE STUDY ON SEXUAL REPRODUCTIVE HEALTH RIGHTS (SRHR) IN MANDERA COUNTY, KENYA

**PROJECT: “*Enhancing Quality and Universal access
to Indigenous People’s reproductive healthcare
(EQUIP)*”**



MARCH 2020

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LIST OF ABBREVIATIONS

ToR	Terms of Reference
SRH	Sexual Reproductive Health
MRG	Minority Rights Group
SDPs	Service Delivery Points
KIIs	Key Informant Interviews
RH	Reproductive Health
CHWs	Community Health Workers
ODK	Open Data Kit
SPSS	Statistical Package for Social Scientists
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Rights
KNCHR	Kenya National Commission for Human Rights
KDHS	Kenya Demographic Health Survey
CIDP	County Integrated Development Plan
ANC	Ante-Natal Care
KHIS	Kenya Health Information System
NGOs	Non-Government Organizations
CBOs	Community Based Organizations
FBOs	Faith Based Organizations
AACs	Area Advisory Council
MPs	Member of Parliament
MCAs	Member of County Assembly
CSOs	Civil Society Organizations
WHO	World Health Organization
TB	Tuberculosis
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
MOH	Ministry of Health
KNBS	Kenya National Bureau of Statistics

EXECUTIVE SUMMARY

The baseline survey was commissioned by Minority Rights Group International in February, 2020 with the aim of collecting, analyzing, reporting detailed disaggregated evidence on disparities in access to Sexual Reproductive Health (SRH) services and identify reliable national and/or county level statistics against which progress can be tracked. Specifically, the objective of the baseline study was to generate the necessary baseline data for the project entitled “Enhancing Quality and Universal access to Indigenous People’s reproductive healthcare (EQUIP)” which is being implemented in partnership with Health Poverty Action (HPA) and IIDA Women’s Development Organisation partners in Kenya.

The survey adopted a mixed-method approach entailing; desk review, quantitative and qualitative methodology. A combination of probability and convenience sampling methods were employed to determine distribution of sample size for the survey. Probability sampling entailed random sampling of target respondents through face to face client exit interviews while convenience sampling involved purposively selecting target respondents based on their involvement in providing and promoting sexual reproductive health services.

Data collection commenced on 17th March 2020 and completed on 26th March 2020, where a total of 100 women were interviewed from the target sample of 100. The target beneficiaries were drawn from 4 health facilities in Mandera East Sub-County including: Koromey Dispensary, Qumbiso Dispensary, Hareri Hosle Dispensary and Buruburu Dispensary.

The overall analysis framework for the survey involved; quantitative data analysis using IBM SPSS Statistics Version 23 and MS Excel while qualitative data was analyzed through thematic and content analysis.

SUMMARY OF KEY FINDINGS

The key findings of the baseline survey are:

1. Several stakeholders are involved in providing and promoting sexual reproductive health services in Mandera County, they include Ministry of Health, County Department of Health, Civil Society Organizations, Politicians (MPs, MCAs, Women Representative, Senator), Community Based Organizations, Faith Based Organizations, Office of the First Lady Mandera County, Office of The First Lady of the Republic of Kenya, Area Advisory Council, Reproductive Health Technical Working Group, Community Health Workers, Clan leaders, media, academia, Area Chiefs, Sub-County Administrators and Religious Leaders among other stakeholders.

2. The baseline survey did not establish any past successful or likely successful SRH policy change processes that has been pursued in Mandera County. Nevertheless, one unsuccessful effort to pursue policy change aimed at increasing budgetary allocation on health was reported, with a focus of subsequently influencing its distribution towards nutrition and reproductive health.
3. Nine out of ten (9/10) women/girls that were consulted in the survey affirmed that the information provided by the service provider was clear by disability, age group and ethnicity.
4. Over (90.0%) of women/girls reported that health service providers showed them respect while administering services. The findings were similar across the three levels of data disaggregation by disability, age and ethnicity.
5. A near universal of all the surveyed respondents reported that they were satisfied with the services received by disability, age and ethnicity.
6. About two in five (38.7%) births were reported to be delivered by skilled birth attendant (**nurses, midwives or doctors**) compared to (61.8%%) at the national level. In addition, (36.0%) of births in Mandera County were reported to have been delivered in a health facility compared to national figure at (61.2%).
7. At national level, (57.6%) of pregnant women/girls aged 15-49 years were reported to have made at least 4 antenatal care visits for their most recent live birth. County data on antenatal care is not available. However, in north eastern region where Mandera County is located, only (36.8%) of women in reproductive age reported to have received antenatal care at least 4 times during pregnancy, which is considerably lower than the national rate.
8. At national level, contraceptive prevalence rate by any contraceptive method among currently married women, aged 15-49 was recorded at (58.0%). Comparative analysis with County figures shows that the national prevalence is noted to be thirty-one times higher than County contraceptive prevalence which was recorded at (1.9%) among currently married women aged 15-49.
9. Available and credible sources of information being used by National government, County government and development partners for purposes of development planning and policy formulation show very limited degree of data disaggregation that presents circumstances of different categories of population, especially minority groups and people living with disability among other vulnerable groups.
10. At the county level the survey did not identify any positive adaptations or data collection exercises that are already in discussion. However, at the national level, KNBS with support from different stakeholders had already began making efforts of commissioning the next Kenya Demographic Health Survey in late 2019 through early 2020. However, this survey was put on hold due to competing priorities and unforeseen circumstances like the COVID19 Corona Virus Pandemic that has brought both government and private sector operations nearly to a halt.

The above key findings together, present considerable challenges to efforts and interventions aiming to work with duty bearers and right holders towards promoting access and uptake of SRH services in Mandera County. Consequently, the baseline survey is of the view that due to the aforementioned findings, actualizing implementation of activities that have been set out to be implemented within the project will be daunting task that might accrue limited outputs and outcomes. Therefore, for the project to realize its aim and objectives, it should seek to pursue strategic partnerships and implementation approaches that will require limited resources and time to implement, with the main aim of achieving substantive outputs and outcomes.

1.0 INTRODUCTION

1.1 Background of the Survey

As articulated in the Terms of Reference (ToR), globally, Sexual and Reproductive Health (SRH) services provided to or accessed by minority and/or indigenous women are significantly worse than to majority populations. Indigenous and minority women and girls die in pregnancy and childbirth more often than other women because, where data exists, on average, they are three times less likely to receive antenatal care and almost half as likely to have skilled attendance at birth. The service design which lacks the consideration of the attitudes and cultural norms of minority and indigenous women may also prevent them accessing and utilizing appropriate SRH services. However, this disparity in SRH services between the populations is masked due to lack of data disaggregation by ethnicity and the limited capacity of the local women and girls and local organizations to get their voice heard. In response to these challenges, EQUIP will use participatory process empowering indigenous women and girls to research and analyze their problems, to pilot solutions by adapting their attitudes and cultural norms, and to voice for their specific needs and quality client-oriented health services.

1.2 Purpose of the Survey

The baseline survey was commissioned to provide the necessary baseline data for the project entitled *“Enhancing Quality and Universal access to Indigenous People’s reproductive healthcare (EQUIP)”* which is being implemented in partnership with Health Poverty Action and IIDA Women’s Organization partners in Kenya. Specifically, the baseline survey focused on:

1. Collecting and analyzing detailed disaggregated evidence on disparities in access to Sexual Reproductive Health (SRH) services and identify reliable national level statistics against which progress can be tracked.
2. Generating a power map that identifies SRH stakeholders in the target areas and past successful or likely successful change processes.

1.3 Key Tasks to be Undertaken by the consultant

The key tasks to be performed by the consultant was to draft and supply IIDA and Minority Rights Group (MRG) with a baseline study that collects and analyses detailed disaggregated evidence on: –

- A. Client Exit Interviews conduct by the consultant targeting 100 women in the target areas to establish:
 - Proportion (%) of minority and/or indigenous women/girls accessing a SRH service in the last six months, by number (%) of those who say “yes” to all 3 of these questions:
 - a) their service provider explained things clearly
 - b) their provider showed respect to them

- c) they are satisfied with the service received (disaggregated by ethnicity, age, and disability)

- B. Research carried out by the consultant into available data in Kenya to also establish:
 1. Number (%) of births delivered with the help of nurses, midwives or doctors, in the target areas (disaggregated by ethnicity, disability and age). Latest existing reliable national and Mandera County data on SRH. The national figures for a) – c) should be derived from a source which will continue to be available to the project in the future. National figures will ideally be disaggregated by age and disability if this is available but no national level data collection is anticipated. The report should include a discussion of the reliability, pros and cons of different sources of national level data.
 2. Number (%) of pregnant women/girls 15-49 years in target areas who have made at least 4 antenatal care visits (disaggregated by ethnicity, disability and age). Latest national and target area data.
 3. Number (%) of contraceptive prevalence rate in target County (disaggregated by ethnicity, disability and age). Latest national and target area figure.
 4. Existence of positive adaptations or modifications of government, UN agency or INGO sexual and reproductive health policy, staff training or service provision for minority and/or indigenous women and girls at local, district or national levels
 5. Degree to which disaggregated data is collected, analysed and reported by the Ministry of Health, Kenya National Bureau of Statistics or any similar reputable source in Kenya.

In addition, for 1) – 3) above the study should elaborate general trends in the statistics over the past 5 years. For 4) and 5) the study should include any planned or likely positive adaptations or data collection exercises that are already in discussion.

- C. Establish a power map that identifies SRH stakeholders in Mandera County and past successful or likely successful change processes illustrating;
 1. brief background of the context
 2. overview of SRH service provision in Mandera County, including Ministry of Health, international providers and local providers of SRH
 3. details and analysis of the SRHR stakeholders
 4. Past successful or likely successful SRH policy change processes.

2.0 THE METHODOLOGY

This section discusses the methodology employed by the baseline survey. It covers the overall approach, methods applied in sampling, collecting data, analysis and presentation of findings of the survey.

The survey adopted a mixed-method approach entailing; desk review, quantitative and qualitative methodology. A combination of probability and convenience sampling methods were employed to determine distribution of sample size for the survey. Probability sampling entailed random sampling of target clients as they leave health facility while convenience sampling involved purposively selecting target respondents based on their involvement in promoting sexual reproductive health services.

The overall analysis framework for the survey involved; quantitative data analysis using IBM SPSS Statistics Version 23 and MS Excel while qualitative data was analyzed through thematic and content analysis.

2.1 Survey Methodology

The process of collecting data for the Baseline Survey applied a mixed-method approach entailing: quantitative and qualitative methodology. The quantitative data collection methodology was largely participatory involving face to face interviews with clients seeking for SRH services as they exit health facilities. The qualitative approach on the other hand involved key informant interviews with key opinion formers and desk review of literature materials that are pertinent to the survey. The mixed methods approach allowed for methodological triangulation of collected data/information which guaranteed accurate, valid and reliable data.

2.2 Sampling

The selection of the respondents who participated in the quantitative face-to-face interviews adopted a simple random sampling strategy which entailed randomly selecting target clients as they left SRH service delivery points (SDPs). Within each health facility, respondents were randomly selected based on number of patients that visited the health facility to seek SRH services on the day of the interview. Clients at Service Delivery Points (SDPs) were interviewed as they left the health facility to obtain views of clients about the services provided by the health service providers. Information obtained were used to assess clients' satisfaction with the type of sexual reproductive health service received, and their appraisal of various service elements related to accessing SRH services provided by health service providers at service delivery points. Specifically, this information was further used to assist in gauging some aspects of the quality of care for SRH services from the client's perspective'.

The authorities of the SDPs were informed and their permission obtained before the client exit interviews were administered for a particular SDP. Most importantly consent of the individual clients were obtained. The interviewers informed the client about the purpose of the client exit interviews. The interviews were conducted in private. Steps were taken to ensure that no other person was present for the interview. Confidentiality was maintained; by ensuring that the interviewers do not discuss the respondents' answers with anyone, except their survey supervisors. Although client exit interviews are not expected to be based on representative samples of the population, however, efforts were made to ensure that they are representative of those who visit the facility on that day of the survey. In this respect the interviewers ensured that those interviewed were systematically where SDPs had high attendance, the interviewers spoke to a sample of clients. The sample was chosen systematically (i.e. every 3rd respondent was chosen from the SRH attendees leaving the SDP on the day of the interview). In SDPs with low attendance, interviewers spoke to all the clients visiting the facility on the day of the interview. A breakdown of the quantitative target and achieved sample composition is detailed in Table 1 below.

Table 1: Quantitative Client Exit target and achieved sample composition

Health Facility	Target Sample	Achieved Sample	Response Rate
Koromey Dispensary	25	25	100.0%
Qumbiso Dispensary	25	25	100.0%
Hareri Hosle Dispensary	25	25	100.0%
Buruburu Dispensary	25	25	100.0%
TOTAL	100	100	100.0%

The qualitative design through KIIs utilized purposive sampling of target stakeholders who are engaged in promoting and providing sexual reproductive health services. A total of 06 KIIs with target stakeholders were successfully administered. A breakdown of the KIIs target sample scope and achievement is detailed in Table 2 below.

Table 2: Qualitative KII target and achieved sample composition

Category of respondent	Target Sample	Achieved Sample
Director of Health Mandera County	1	0
Sub County Health Officers	1	0
County RH Coordinator	1	1
Women Groups	1	1
Religious Leaders	1	1
Community Based Reproductive Health Agents	1	1
Sub-County Public Health Nurses	1	0
CHWs	1	0
Other NGOs	1	1

Community Opinion Leaders	1	1
TOTAL	10	6

2.3 Data Entry, Analysis and Presentation of Quantitative Data

Quantitative data entry was carried out via mobile technology using android Mobile operating system. The questionnaire was programmed in Open Data Kit (ODK) to ensure that quality controls were integrated during data collection and entry processes. These include programming the questionnaire to ensure that: logic and consistency checks are streamlined, responses entered are within valid ranges, responses between questions are consistent, and skip patterns are followed as required by the questionnaire. Thus, the mobile technology ensured the required data quality at collection and entry level are achieved and obviated the data quality challenges associated with paper-based administration of questionnaires. Statistical Package for Social Sciences (SPSS) Version 23 and MS Excel were the main programs for data analysis. The analysed data was presented in the form of single-variable and multi-variable frequency tables, pie-charts and graphs. Further, where applicable, exploration of the relationships between two or more variables through cross-tabulation was also done and presented through frequency tables and graphs.

2.4 Training and preparation of evaluation team

Prior to commissioning data collection exercise, a total of 5 research assistants comprising 2 females and 3 males were trained mainly on five key areas: instrument administration; interview techniques; procedures and skills; importance of the survey and research process. The training was administered remotely for one day, and it focused on specific objectives that included; familiarization with the study TOR; survey questions and questionnaire flow; recording of information; integrity during data collection; and informed consent and confidentiality as key components of research ethics.

2.5 Ethical Considerations

Prior to conducting interviews with all target respondents, oral consents were sought and obtained from literate and illiterate respondents respectively after being explained to the purpose of the survey in a language that they fully understood.

2.6 Limitations of the Baseline Study

During the implementation of the baseline survey, one key challenge was observed that affected the process of data collection especially those targeting key informants. During data collection exercise COVID-19 pandemic struck Kenya. To deal with the pandemic all stakeholders working in the health sector shifted all their focus into managing and containing the effects of the pandemic. Due to change in focus, this made it challenging

to secure interviews with stakeholders drawn from health ministry and law enforcement agencies.

2.7 Sample size and sample size distribution

As articulated in the Terms of Reference, Client Exit Interviews targeted a total of 100 clients leaving the facility service delivery points for SRH services on the day and time of the interview. This total sample was distributed 4 health facilities that were targeted in the survey namely: Koromey Dispensary, Qumbiso Dispensary, Hareri Hosle Dispensary and Buruburu Dispensary. Within each health facility a fixed number of 25 interviews were distributed across the health facilities. All the four health facilities were drawn from Mandera East Sub-County where EQUIP project interventions is targeting. To achieve the targeted sample size the survey team devised strategies for collecting information from as many persons as possible. Depending on the survey location, specific times of the day (e.g., morning hours); specific days (market days for some rural communities); or designated clinic days etc., were explored to reach as many attendees as possible. Out of the targeted 100 interviews, the baseline survey achieved 100.0% response rate.

3.0 SURVEY FINDINGS

3.1 A POWER MAP

3.1.1 Brief Background of The Context

Sexual and reproductive health (SRH) is a fundamental human right as well as human development issue that states must strive to fulfil. This right is guaranteed in various international and regional human rights instruments as well as national laws and policies. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents (KNCHR, April 2012).

According to 2019 Housing and Population Census results¹, Mandera County has a total Population of 867,420 thousand people. Of this population (17.2%) are children aged below 15 years, (18.6%) are aged under 5, (29.7%) are aged 10-19 years and (19.8%) are women/girls aged 15-49 years. The average household size in Mandera is the highest in the Country at 6.9 household members compared to national figure that stands at 3.9.

For a long time, health services in Mandera County has been marred with profound high prevalence of disease burden, runaway maternal/infant mortality and poor child survival among other health and disease outcomes. Mandera County has the lowest uptake (1.9%) of any contraceptive methods among married women aged 15-49 years, about 29 times lower than the national average (58% - KDHS 2014). The low uptake is largely driven, at least in part, by lack of access to quality maternal health services, including ante-natal, delivery, and post-natal services; long spans of marginalisation, insecurity, weak health systems, distance to a health facility, cost of contraceptive service, and retrogressive cultural and religious practices among other barriers to accessing quality care. Mandera County's total fertility rate (5.2) is higher than the national rate of 3.9 which demonstrates that Mandera County has a high birth rate where a woman in Mandera County can expect to have 5 children in her lifetime. Further, it was prominent that adolescent birth rate is notably lower than the national rate of 96 births per 1000 girls aged 15-19. In Madera, about 3 out of every 1000 (29) babies is born to an adolescent girl aged 15-19 (Mandera County Fact Sheet, June 2017).

¹ <https://www.knbs.or.ke/?p=5732>

Maternal, neonatal and under-five mortality is alarming in Mandera. The maternal mortality ratio was 3,795 for every 100,000 live births, about eight times higher than the national average (362 for every 100,000 live births-KITHS 2014) (CIDP, 2018-2022). Child death rates in Mandera County reflect the national trend although neonatal death rates are slightly higher and infant and under five death rates are slightly lower. High maternal and child death rates are linked to high birth rates and limited access to life saving maternal and child health interventions (Mandera County Fact Sheet, June 2017²). These undesirable statistics were attributed to a myriad of reasons, that include low uptake of skilled birth attendance (28% - KDHS 2014), poor road transport to enhance referrals, few functional health facilities (53 existing but only 3 were functioning at 10%), inadequate health workforce (vacancy rate of 97%), inadequate commodities, supplies, equipment and medical devices, poor referral system, community related delay factors, lack of multi-sectorial approach, weak or lack of support supervision, quality assurance, clinical audits, operations research and procurement system (CIDP, 2018-2022³).

Since the introduction of devolved system of governance in 2013, Mandera County Government embarked on strategic interventions to reverse the maternal mortalities and improve on the maternal healthcare through fresh investments in the health sector by capacity building health care workers, constructing, rehabilitating and equipping old and new health facilities. Most of the health facilities now offer basic neonatal and obstetric care services while 6 sub-county hospitals facilities offer comprehensive obstetric and emergency care. Up to 70% percent of the health care workers have been trained on EMOC through support of health partners. Many mothers now trust public health facilities, which has increased the skilled birth attendance to 34%, while 4th ANC visit stands at 36%. This has considerably reduced the maternal mortality rate in the county (CIDP, 2018-2022).

3.1.2 Overview of SRH service provision in Mandera County, including Ministry of Health, international providers and local providers of SRH

Exploring configurations and constellations of various categories of stakeholders often form a core component of any useful problem driven stakeholder's analysis. This is because stakeholders often play instrumental roles in shaping institutions (both formal and informal) that are integral to addressing a problem. This segment explored the configuration of stakeholders in order to identify the critical players that are important to understand their intentions, interests and influence in SRH service provision in Mandera

² <https://www.afidep.org/resource-centre/downloads/fact-sheets/reproductive-maternal-neonatal-child-health-mandera-county/>

³ <https://mandera.go.ke/county-policies/>

County. This was aimed at developing an understanding of who to engage and in what ways to achieve the most impact towards promoting sexual reproductive health services in Mandera County.

Table 3 below illustrates a classification of some of the major stakeholders in Mandera County that were considered to have interest and power to influence to promote access and uptake of sexual reproductive health services. This is either through determining changes in norms, practices and attitudes or influencing implementation of policy, effectiveness of institutions and enforcement of legal frameworks on aimed at promoting sexual and reproductive health services. Below is an excerpt from the one of the key informant respondents that was consulted in the survey.

“There are several stakeholders engaged in promoting SRH services in Mandera County, to start with there are non-governmental organizations who are promoting and providing SRH services. There are also religious leaders and opinion leaders, county and national government department, chiefs, assistant chiefs and Sub-County Commissioners among others. In addition, we have a technical working group, or the reproductive health technical working groups whose members are drawn from non-governmental organizations implementing RH services in Mandera County. The technical working group normally convene their meetings on quarterly basis. These meetings normally provide an avenue where information is shared with County Director of Health including its members. Within the technical working groups there are certain set of reproductive health outcome indicators that are normally tracked and reported on quarterly basis to assess their performance and progress. This information is normally generated from Kenya Health Information System (KHIS). Addition to tracking the indicators, we also normally discuss challenges we are facing in our work, how to mitigate them, actions we need to adopt to improve our work and to pursue more strategic partnerships with stakeholders who are not members of the technical working group.”

Key Informant Interview, Civil Society Organization Representative

Table 3: Constellation of Reproductive Health Stakeholders in Mandera County

High Interest; Low Influence	High Interest; High Influence
<ul style="list-style-type: none"> - NGOs; CBOs; FBOs - Community Health Workers - Women/girls - Office of the First Lady, Mandera County - Reproductive Health Technical Working Group 	<ul style="list-style-type: none"> - County Department of Health - County Director of Health Services - County Coordinator - Reproductive Health Services - Ministry of Health_National Level - Officer of the First Lady, Republic of Kenya (Beyond Zero Campaign) - Area Advisory Councils (AACs) - Media

Low Interest; Low Influence	Low Interest; High Influence
<ul style="list-style-type: none"> - Academia - General public/community members - Junior Clan elders 	<ul style="list-style-type: none"> - Top Clan elders - Men/Boys - Religious leaders - County Assembly/National Parliament - Politicians (MPs, MCAs) - Sub-County Administrators - Area Chiefs (provincial administration)

3.1.3 Details and Analysis of The Stakeholders

A. High Interest and Low Influence: Empower

This comprises stakeholders that were deemed of high interest but with low level of power to influence implementation of policies and legal frameworks that promote access and uptake of SRH services. The analysis found them of high interest due to their obligation and involvement promoting SRH services. This was especially for civil society organizations (NGOs, CBOs and FBOs) and community health workers. The survey also noted women/girls in their reproductive age as high interest low influence stakeholders because of the agency of SRH outcomes on their health, livelihoods and social standing. This category of stakeholders was deemed of low influence because of their inability to substantively impact the changing of norms, practices and attitudes on SRH services and also to ensure effective implementation of the policies and legal frameworks that promote SRH services. The understanding was that whilst CSOs for example have made efforts to educate communities on the importance of SRH services, the practice remains prevalent in many such areas because there remain other factors at play that impair the effectiveness of their work – like the role of culture and custodians of culture that hinders uptake of SRH services. For institutions of government placed in this category like Office of the First Lady Mandera County, the understanding was that despite their mandates, they lack legal or political muscle to change practices, norms and attitudes that promotes access and uptake of SRH.

This category of stakeholders if engaged, and supported with continuous capacity development and education on the laws, policies and harmful implications of not utilizing SRH services can be leading change agents. It is advisable that EQUIP project should consider to engage them with structured efforts targeting to deal with issues that limit their influence. For example, through continuous education of women/mothers and dialogue between them and girls, a movement of female champions that promote SRH services can emerge amongst women and girls. Likewise, if supported to develop capacity and organizational structures, CBOs and other CSOs in the county can function as effective agents of change, coordinating and supporting interventions targeting to promote access and uptake of SRH services since they have contextual knowledge, understand the

cultural dynamics and have community buy in/acceptance since they are themselves members of these communities. This category therefore ought to be kept well informed of the activities of EQUIP Project.

B. High Interest - High Influence: Actively Engage

This segment represents stakeholders with high levels of interest and high-power endowment to influence policy and legal framework around promoting access and access of SRH services. The analysis found this category comprising of: County Department of Health, Ministry of Health and Office of the First Lady of Republic of Kenya (Beyond Zero Campaign) amongst others. Essentially, this category of stakeholders represented those who stand affected by the low access and uptake of SRH services and who can do something about it whether through changing practices and norms or through enforcement of the law to promote SRH services.

For instance, Institutions of government involved in policy making and law enforcement were cited as stakeholders of high interest and high influence in promoting SRH services. They retain the legal mandate to make and implement policy on promoting SRH services. Through their efforts, more resources can be allocated, awareness and public education done and the law enforced to promote access and uptake of SRH services. They should by default be highly interested in any work aimed at promoting SRH services. However, there were sentiments alluding to the fact that institutions of government at the local level remain constrained by resource challenges, unwillingness to promote SRH agenda amongst some government officers, and capacity limitations on how to promote SRH services that sometimes undercut their efforts. Through structured capacity development activities targeting local level (county) institutions of government like departments of reproductive health services can function effectively as mechanisms for ensuring effective implementation of SRH services.

The media, especially local community radios, were deemed to have a lot of interest in working towards promoting SRH services and have substantive influence over the general population. This is especially considering their role in public education and information sharing. There were indications that some CSOs and government departments are already working with local media to increase awareness and dialogue on SRH services. It is important that more engagement of the media, capacity development be done to empower them further and improve their capability to share powerful messages on SRH that can reach clan elders, youth, girls, women, government and community at large.

As such, closely and strategically engaging and managing this category of stakeholders is perhaps the most important in determining progress of EQUIP project towards enhancing quality and universal access to Indigenous People's reproductive healthcare.

C. Low Interest - High Influence: Keep Satisfied and Win over

This category of stakeholders represents those with a lot of power and are capable of influencing the abandonment or continuation of retrogressive cultural norms that hinder people from using SRH services by determining changes in norms, practices and attitudes or influencing implementation of policy, effectiveness of institutions and enforcement of the law that promote use and uptake of SRH services. However, they are not substantively motivated or interested in pursuing or engaging on the issue. Key stakeholders mapped in this category included: Top Clan elders, Religious leaders, County Assembly/National Parliament - Politicians (MPs, MCAs), Sub-County Administrators and Area Chiefs (provincial administration).

Top clan elders for example hold the greatest power over determination of use and uptake of SRH services because they are custodians of culture that is largely driven and sustained by cultural belief that certain SRH practices like family planning among others are not acceptable culturally because there is a belief that one is allowed to bear as many children as they can irrespective of their socio-economic ability to take care of them. Therefore, efforts to promote SRH services must include their engagement and securing of their buy-in. However, as many actors have now established, and as argued by most of the respondents consulted in the survey through key informant interviews, top clan leaders remain tightly attached to the value of culture and display unwillingness to consider discussing abandonment of retrogressive cultural practices that hinder uptake of SRH services. Top clan elders there remain highly powerful/influential but with very limited motivation to lead, champion or oversee efforts to promote access and uptake of SRH services.

There was also substantive agreement amongst respondents that politicians remain very influential in the various localities. They form a strong network through which intelligence is gathered, information shared and support law enforcement. They are known to have strong knowledge of the contextual issues, the terrain and with 'ears on the ground'. They thus have considerable power and capability to promote access and uptake of SRH services especially in rural areas where minority groups are found. However, it was, from respondents, that save for a few who are enlightened and who have bought into the idea of promoting SRH services, most of them show little interest in dealing with the issue.

The baseline survey findings encourage that this category of stakeholders be kept satisfied and pursued for engagement in order to win them over and recruit them to be

supporters, champions or patrons of the course. It is prudent therefore that EQUIP project considers increasing engagement, capacity development and awareness creation amongst this category in order to increase the mass of stakeholders in support of promoting access and uptake of SRH services.

D. Low Interest - Low Influence: Engage and Empower

The fourth category of stakeholders was the group which demonstrated low level of interest in the issue and equally have low power to influence other stakeholders to effect change around the issue. Here, the analysis plotted such stakeholders as: academia, general public/community members, and lower level or junior clan elders. Essentially, the finding here was that there were actors who appeared without any substantive influence on the norms, practices and attitudes either because they are not custodians or determinants of culture or lack legal or institutional mandate to do anything about promoting SRH services. It was notable, for example, that people in academia who were argued to be more learned and enlightened about possible gains SRH services brings, were not necessarily leading the way towards promoting SRH services. In fact, some respondents argued that some very educated people have been the ones giving births to so many children rather than advocate for change in such harmful cultural practices. Equally, many of the junior clan elders were noted to have limited interest and influence to change the way things are. Notably, going by the power dynamics and structure of clan leadership across Mandera County, the lower level elders despite their interest characteristically have low level power/influence to affect any substantive change in important cultural practices that hinder uptake of SRH services without declarations by top level clan elders. It was evident that the general community, whilst sometimes displaying some level of concern over the detrimental effects brought about by lack of SRH services, largely remained lukewarm about actively engaging, and organizing on their own to discuss how to deal with promotion of SRH services. The larger public/members of the communities remain dependent on direction and governed by decrees/pronouncements by top clan leaders on issues to do with culture. It is possible, through continued public education and awareness creation and clan dialogue including intergenerational dialogue) to increase the understanding of harmful effects brought about by lack of SRH services amongst community members and the need to openly discuss retrogressive cultural practices that hinder its uptake in order to increase understanding of what they can do to help promote SRH services.

3.1.4 Past successful or likely successful SRH policy change processes

A Policy is a regulation or a guideline that documents set of activities, programmes, services or action that should be followed and observed during service delivery. At national level the survey noted that over the past two decades Kenya has made positive advancements to enact progressive model policies that promote access and uptake of

SRH services. At the County level the baseline survey did not establish any past successful or likely successful SRH policy change processes that has been pursued in Mandera County. However, one unsuccessful effort to pursue policy change on SRH was reported. The policy change process was advanced to lobby the County Assembly Committee of Health to increase budgetary allocation on Health, and how it could be distributed within the different health dockets including nutrition and reproductive health. The policy change process was being spearheaded by a network of organizations implementing health activities in Mandera County called Scaling Health Nutrition Civil Society Alliance. These efforts were complimented with those from other stakeholders including The First Lady of Mandera who was appointed to champion the policy change process. Despite the substantive resources committed to facilitate such efforts, the policy change process did not materialize into any success due to lack of political goodwill from the county assembly to allocate additional budget to support the struggling health docket.

3.2 CLIENT EXIT INTERVIEWS

3.2.1 Respondents Demographic Analysis

A summary of demographic analysis of respondents consulted in the baseline survey through face to face interview is provided in Table 4 below. As illustrated in the table, one out of ten (1/10) of the surveyed respondents were reported to be living with disability where all the respondents who confirmed that they were experiencing a lot of difficulty together with those that could not at all see, hear, walk and remember were considered disabled. It was notable that (90.0%) of the respondent were considered illiterate because they could not read and write in English and Swahili language against (73.0%) who confirmed that they could read and write in Somali language. It was evident from the survey that considerable proportion of the respondents were drawn from Garre (37.0%), Murulle (29.0%) and Conner tribe (25.0%). Slightly over half (54.0%) of the respondents were nomadic pastoralists against (46.0%) who reported that they belonged to sedentary cultural grouping. The main source of livelihood for the surveyed respondents are pastoralism (45.0%) and casual employment (32.0%). A near universal (96.0%) of the respondents reported that they were currently married.

Table 4: Respondents Demographic Analysis

Demographic Characteristic	Question	Options	Overall Proportion (%)
Disability	a. Seeing, even if using glasses?	No, no difficulty	88.0%
		Yes, a little	7.0%
		Yes, a lot	5.0%
		Cannot do at all	0.0%
	b. Hearing, even if using a hearing aid?	No, no difficulty	86.0%
		Yes, a little	10.0%
		Yes, a lot	3.0%

		Cannot do at all	1.0%
	c. Walking, climbing stairs or carrying items?	No, no difficulty	86.0%
		Yes, a little	7.0%
		Yes, a lot	4.0%
		Cannot do at all	3.0%
	d. Concentrating or remembering?	No, no difficulty	78.0%
		Yes, a little	13.0%
		Yes, a lot	5.0%
		Cannot do at all	4.0%
Literacy Levels	a. Somali (mother tongue)		
	Somali (mother tongue)	Poor	8.0%
		Basic	19.0%
		Good	73.0%
	b. Swahili		
	Swahili	Poor	89.0%
		Basic	7.0%
		Good	4.0%
	c. English		
	English	Poor	92.0%
Basic		0.0%	
Good		8.0%	
Marital Status	Are you currently married or living together with someone as if married?	Yes, currently married	96.0%
		Not currently in union	2.0%
		Divorced/separated	1.0%
		No, never in union	1.0%
Ethnicity	From which ethnic community do you belong?	Garre	37.0%
		Murulle	29.0%
		Degodia	1.0%
		Marehan and	2.0%
		Muhammad Zuber or 'corner tribes	4.0%
		Borana	1.0%
		Conner tribe	25.0%
		Kamba	1.0%
Cultural Grouping	Which of the following class of cultural grouping do you belong?	Nomadic Pastoralist	54.0%
		Sedentary	46.0%
Source of Livelihood	Which is your MAIN source of livelihood	Pastoralism	45.0%
		Agro-Pastoralism	4.0%
		Business	8.0%

	Casual Employment	32.0%
	General good	1.0%
	House wife	9.0%
	Laborer's	1.0%

Further analysis of the survey findings to explore type of SRH service sought for by the respondents shows that general health services were the most sought for services at (51.0%), followed by family planning at (20.0%) and Maternal health at (16.0%). Analysis by age group shows that general health was mainly sought by respondents aged 50+ years (Figure 1).

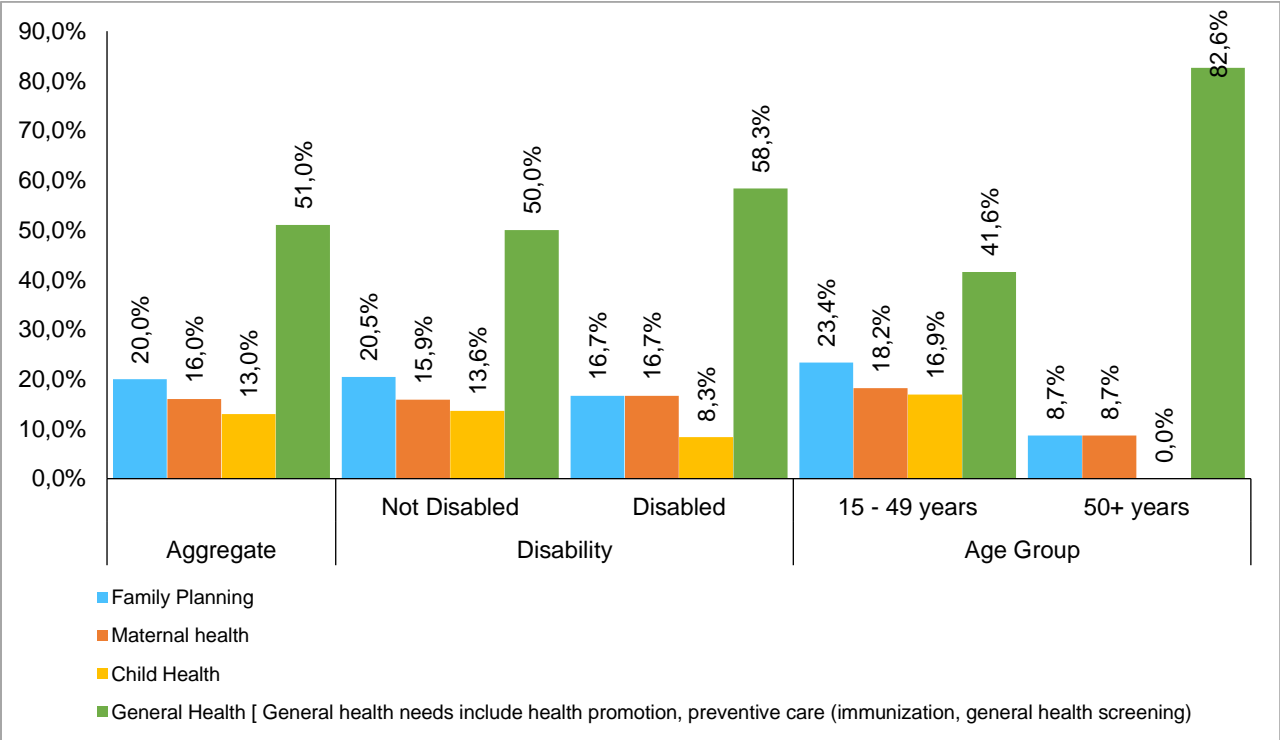


Figure 1: Type of SRH service sought for

3.2.2 Proportion (%) of women/girls who say that their service provider explained things clearly (disaggregated by ethnicity, age, and disability)

Every patient has the right to be informed about the health services, costs and treatment options available to them, and receive timely communication in a way they can understand. Effective communication between a health practitioner and their patient can improve overall satisfaction and contribute towards better long-term health outcomes. How well a patient understands the information provided can also have an impact on healthcare decisions they might make in future⁴. If a patient does not understand the information they receive, there may be an increased risk of instructions being followed

⁴ <https://www.oho.qld.gov.au/wp-content/uploads/2015/10/Effective-communication-in-healthcare.pdf>

incorrectly, or an adverse event occurring. Analysis of survey findings to ascertain respondents' level of satisfaction with clarity of information provided by the service provider shows that nine out of ten (9/10) women/girls that were consulted in the survey affirmed that the information provided by the service provider was clear by disability, age group and ethnicity (Figure 2).

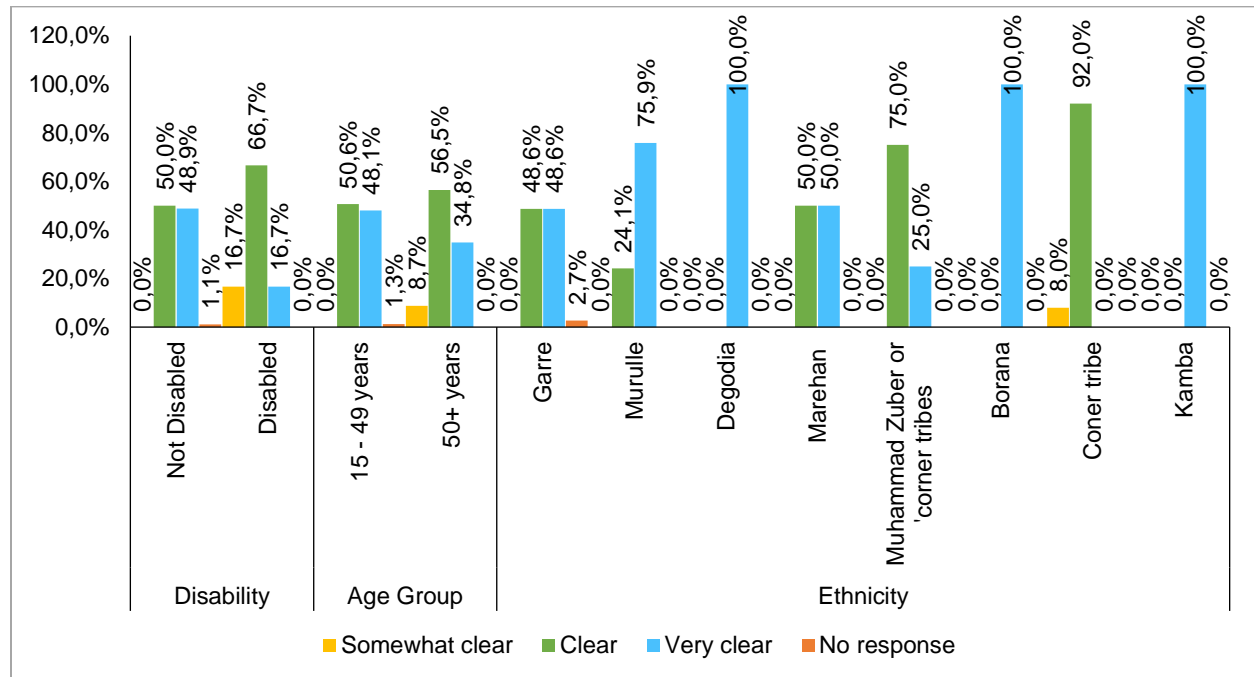


Figure 2: How clear was the health-related information you received today?

3.2.3 Proportion (%) of women/girls who say that their service provider showed respect to them (disaggregated by ethnicity, age, and disability)

Among the most important human needs is the desire for respect and dignity. It helps to create a healthy environment in which patients feel cared for as individuals, and members of health care teams are engaged, collaborative, and committed to service. Within a culture of respect, people perform better, are more innovative, and display greater resilience⁵. Across three levels of data disaggregation by disability, age and ethnicity, the survey findings noted that over ninety percent of women/girls reported that health service providers showed them respect while administering services (Figure 3).

⁵ <https://leanforward.hms.harvard.edu/2018/07/31/setting-the-stage-why-health-care-needs-a-culture-of-respect/>

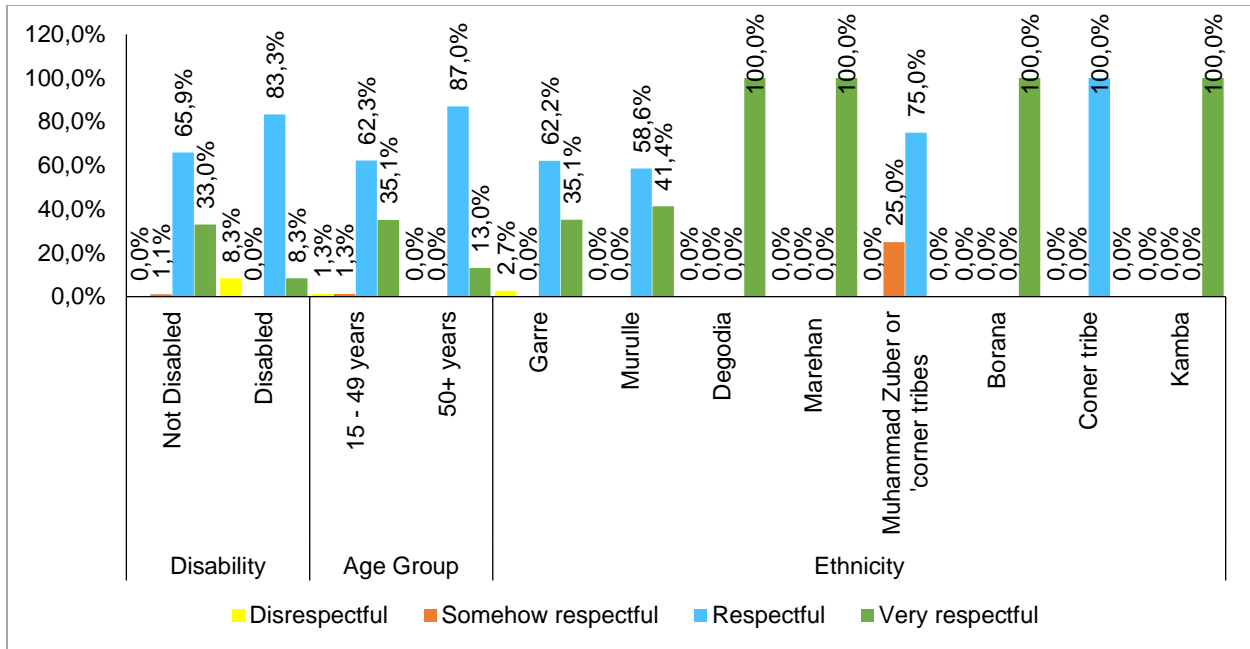


Figure 3: During this visit how respectful was the service provider and other staff to you?

3.2.4 Proportion (%) of women/girls who say that they are satisfied with the service received (disaggregated by ethnicity, age, and disability)

Patient satisfaction is significant and commonly used indicator for measuring the quality in health care as it offers information on the provider's success at meeting clients' expectations and is a key determinant of patients' perspective behavioral intention. Patient satisfaction affects clinical outcomes, patient retention, and medical malpractice claims. It affects the timely, efficient, and patient-centered delivery of quality health care. Analysis of survey findings by disability, age and ethnicity portrays nearly similar picture where a near universal of all the surveyed respondents reported that they were satisfied with the services received (Figure 4).

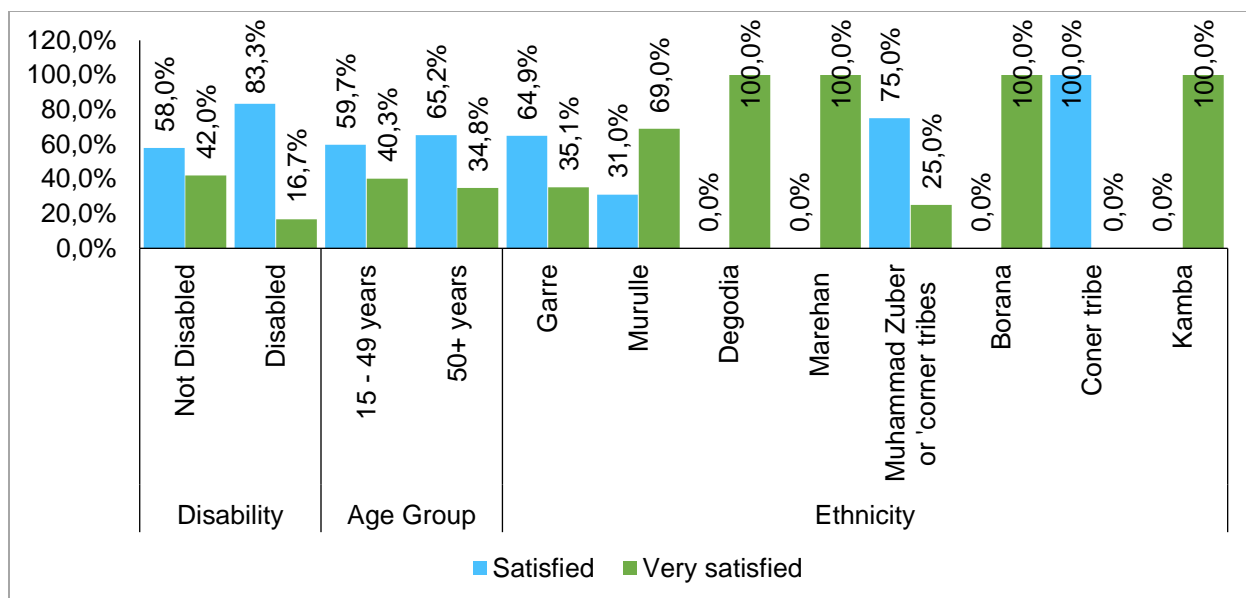


Figure 4: Overall, how satisfied are you with the services you received at this facility today?

3.3 DESK REVIEWS

3.3.1 Number (%) of births delivered with the help of nurses, midwives or doctors, in the target areas (disaggregated by ethnicity, disability and age).

Presence of a skilled health professional (doctor, nurse or midwife) before, during and after delivery is essential in reducing maternal and child deaths. It is recognized as one of the most cost-effective interventions to save lives of millions of women and new-borns. The skilled and accredited health professionals (doctor, nurse or midwife) are considered to have been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns⁶. Review of Kenya Demographic Health Survey report (2104) show that in Mandera County, about two in five (38.7%) births are delivered by skilled birth attendant (**nurses, midwives or doctors**) compared to (61.8%) at the national level (Figure 5). Further examination of survey findings shows that (36.0%) of births in Mandera County were reported to have been delivered in a health facility compared to national figure at (61.2%).

“Comparing the population of women in their reproductive age in Mandera which stands at 171,566 as per the 2019 population and housing census and the number of births delivered by skilled health professional at a health facility is still very low. For instance, a big health facility like Mandera County Referral Hospital approximately records 100 to 150 deliveries per month, considering fertility rate

⁶ https://www.who.int/reproductivehealth/topics/mdgs/skilled_birth_attendant/en/

and population of women in their reproductive age in Mandera, these number of births being registered at a health facility are very low. These statistics demonstrates that quite higher number of births are being delivered at home with the help of unskilled birth attendants.”

Key Informant Interview, Civil Society Organization Representative

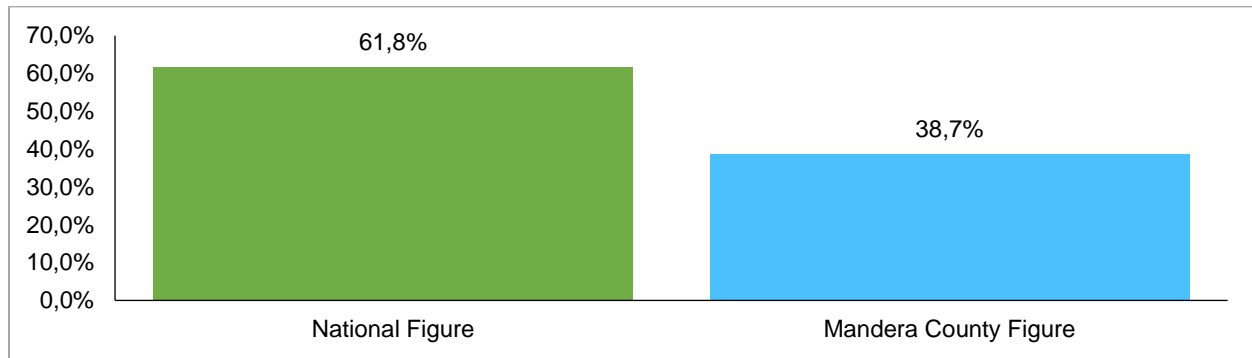


Figure 5: Percentage of live births delivered by skilled birth attendant (nurses, midwives or doctors)

Data disaggregation was presented by age, antenatal care visits, place of delivery, residence, region, mothers’ education and wealth quintile. Data disaggregation by ethnicity and disability was not presented while disaggregation by age was presented only at national level where considerable proportion (63.1%) of births were reported to have been delivered by skilled birth attendant (Figure 6)

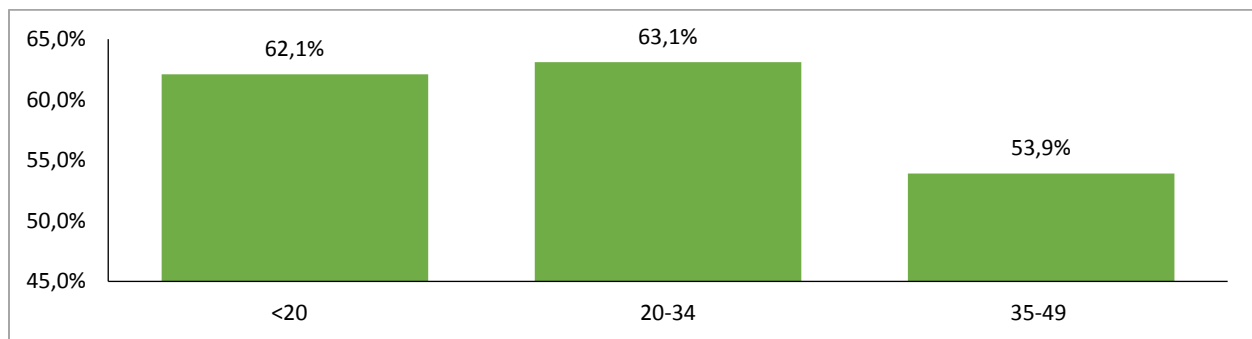


Figure 6: Percentage of live births delivered by skilled birth attendant (nurses, midwives or doctors) at National level by Age

3.3.2 Number (%) of pregnant women/girls 15-49 years in target areas who have made at least 4 antenatal care visits (disaggregated by ethnicity, disability and age).

Antenatal care is universally acknowledged and promoted as the underpinning for improving maternal health outcomes and reducing maternal mortality. To achieve the full life-saving potential that ANC promises for women and babies, World Health Organization (WHO) in the year 2002 adopted a package called focused antenatal care approach that recommends 4 antenatal care visits that are focused on providing essential based interventions. Analysis of Kenya Demographic Health Survey illustrates that at national

level (57.6%) of pregnant women/girls aged 15-49 years were reported to have made at least 4 antenatal care visits for their most recent live birth five years preceding the date of the survey.

County data on antenatal care is not available. In North Eastern region, where Mandera County is located, only (36.8%) of women of reproductive age reported to have received antenatal care at least 4 times during pregnancy, which is considerably lower than the national rate of 58.0% (Figure 7). Further analysis of survey findings shows that North Eastern Province recorded substantive proportion (25.2%) of women in their reproductive age reported to have not attended antenatal care visits. One of the key informants had this to say:

“ANC visits in Mandera County are very low. We are usually faced with situations where a pregnant woman comes for the first ANC visit then they disappear, only to report back during delivery. Majority of births reported in health facilities in Mandera County normally oscillates between 2 – 3 ANC visits.”

Key Informant Interview, Civil Society Organization Representative

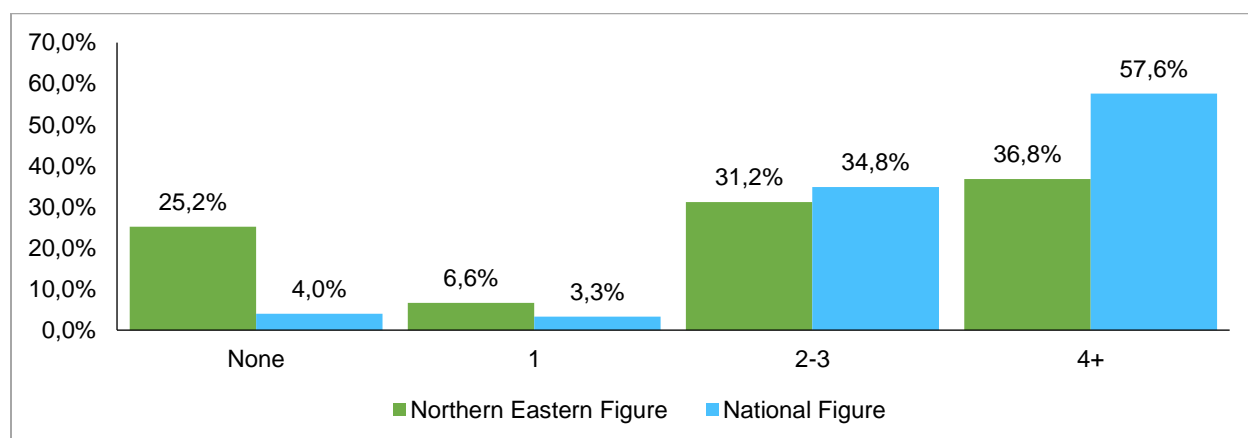


Figure 7: Number of antenatal care visits

Data disaggregation was presented by residence, region, number of ANC visits and number of months pregnant at time of first ANC visit. The levels of disaggregation (ethnicity, disability and age) being sought for by the survey were not presented in the report.

3.3.3 Number (%) of contraceptive prevalence rate in target County (disaggregated by ethnicity, disability and age).

Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in union women aged 15 to 49⁷. Analysis of 2014 Kenya Demographic Health Survey report shows that at national level

⁷ https://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/

contraceptive prevalence rate by any contraceptive method among currently married women, aged 15-49 was recorded at (58.0%). Comparative analysis with County figures shows that the national prevalence was noted to be thirty-one times higher than County contraceptive prevalence which was recorded at (1.9%) among currently married women aged 15-49 as illustrated in Figure 8 below. Below is an excerpt from one of the key informants that were consulted in the baseline survey, he had this to say.

“Contraceptive prevalence or family planning is the worst form of sexual reproductive health service that is performing badly in the County. In fact, from experience we usually don’t mention the term family planning to the target beneficiaries including community members in Mandera because the term ‘family planning’ is not accepted by the communities. To some extent men will ask you what did you say. Instead, we adopted the use the of the term “Child Spacing” which is friendlier and more acceptable. Family planning uptake is very low in Mandera, in 100 mothers there is like 10 mothers who might be accessing this service. Not that the services are not found in the facilities, but the cultural and individual belief among other factors is what is hindering these services. Among the women who access these services, majority of them don’t have the consent from their partners. The major issue is when a woman tells her husband that she is going for family planning, the next day she might even be divorced because of difference in opinion in instances where the partners insists that he wants children whereas the woman says she wants to control number of children she needs to bear.”

Key Informant Interview, Civil Society Organization Representative

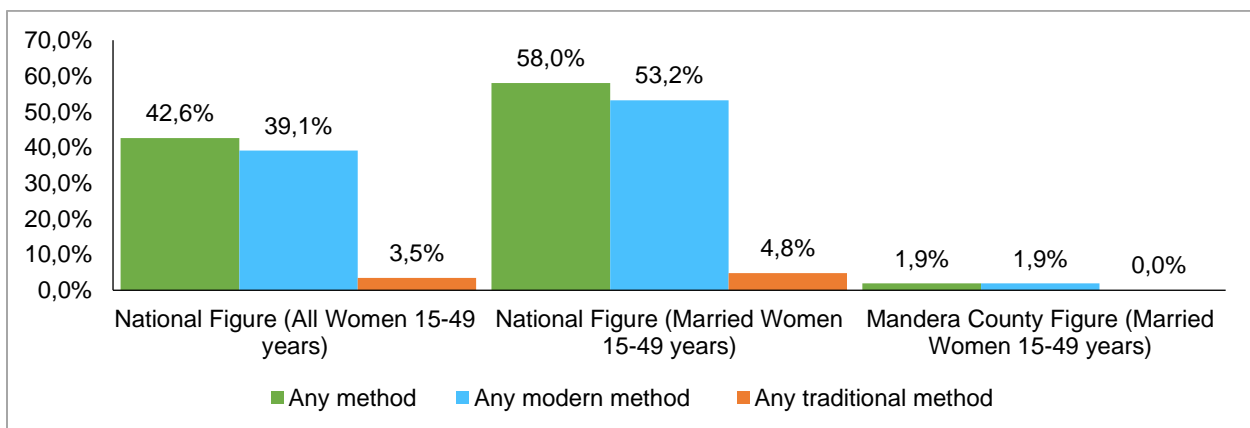


Figure 8: Contraceptive prevalence rate

At the county level data disaggregation was presented by type of contraceptive use only, whereas at the national level disaggregation was presented by age, number of living children, residence, region, education and wealth quintile. As sought by the survey, contraceptive prevalence rate was not presented by disability and ethnicity both at the

national, region and county level. Analysis of contraceptive prevalence rate at the national level shows that the three age groups of women in their reproductive age that were pronouncedly noted to be using any method of conceptive are drawn from age bracket of 30-34 years at (57.5%), 35-39 years at (55.7%) and 24-29 years at (54.2%) as presented in Figure 9 below.

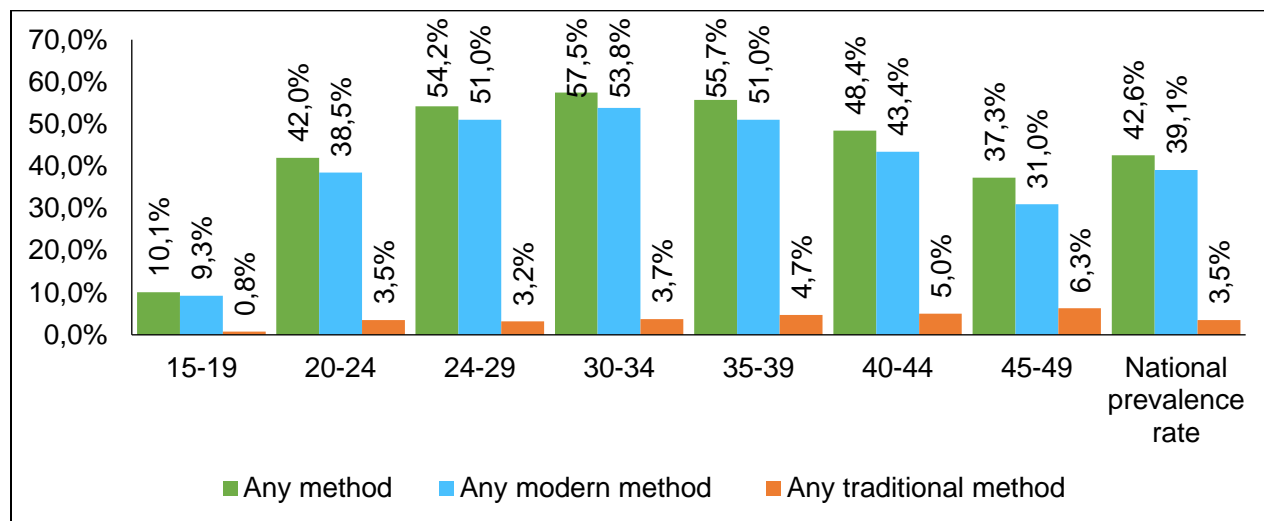


Figure 9: Contraceptive prevalence rate at national level by Age

3.3.4 Existence of positive adaptations or modifications of government, UN agency or INGO sexual and reproductive health policy, staff training or service provision for minority and/or indigenous women and girls at local, district or national levels

The Kenyan policy and legal framework environment for the provision of SRH information and services is generally open and favourable. At the regional level, Kenya is a state party to various international and regional human rights instruments that guarantee the right to sexual and reproductive health. At the regional level, we have The African Charter on Human and Peoples’ Rights (1981); African Charter on the Rights and Welfare of the Child (1990); the Plan of Action (2005 – 2015); Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa or the “Maputo protocol (2003). Others include the Sustainable Development Goals, Abuja Declaration (2001) on HIV and AIDS, Tuberculosis (TB) and other related Infectious diseases; Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) (2009) among others.

At national level the government of Kenya has formulated and enacted progressive legal and policy frameworks that advance rights to sexual reproductive health services. The Constitution of Kenya 2010 guarantees the rights of an individual to the supreme attainable standard of health, including reproductive health. In addition to the Constitution, Kenya has a number of Acts of Parliament that seek to promote and protect sexual and reproductive health rights, which include the Sexual Offences Act 2003, the Children’s

Act 2001, Prohibition of Female Genital Mutilation Act 2011 among others. There are also a number of policies and strategies on sexual and reproductive health including the Kenya Health Policy (2014-2030), Kenya RMNCAH Investment Framework (2016), the National Reproductive Health Policy (2007), and the Adolescent Sexual and Reproductive Health Policy (2015), the National Reproductive Health Strategy 2009-2015; the Adolescent Sexual and Reproductive Health and Development Policy (2003); the National Condom Policy and Strategy (2009-2014); the Contraceptive Policy and Strategy (2002-2006); the Contraceptive Commodities Procurement Plan (2003-2006); the Contraceptive Commodities Security Strategy (2007-2012); the School Health Policy; the Female Genital Mutilation/Cutting Policy; the HIV and AIDS Strategic Plan (2015-2019); Kenya Aids Strategic Framework (2018), the National Reproductive Health and HIV and AIDS integration Strategy-August 2009; the National Reproductive Health Policy Enhancing Reproductive Health Status for all Kenyans, October 2007; the National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and New-born Health in Kenya, August 2010 among others⁸.

These international, regional and national instruments place an obligation on the state to respect, protect, and fulfil the sexual and reproductive health rights of all Kenyans by ensuring that essential services are available, accessible, acceptable and of good quality. Further, these instruments underscore on: the standard of services to be provided by the type of health facility, skills of health professionals to provide the services by level of training and importance of prioritising the needs of vulnerable and marginalised groups in provision of sexual and reproductive health services.

Analysis of survey findings shows that some of the stakeholders that were consulted in the survey echoed that in spite of the available progressive policies and guidelines, still there exists inadequate monitoring of the implementation of the policies and guidelines by MOH and other key line ministries and departments. This has resulted into continued violation of sexual and reproductive health rights of Kenyans in relation to: unavailability of essential sexual and reproductive health services, difficulties in accessing these services owing to distance or cost, the high charges levied on the services, making them beyond the reach of majority poor, the poor quality of the available services, the lack of sensitivity to the cultural norms and beliefs of the people in service delivery and inadequate government commitment to comply with its obligations.

To realize SRH rights as documented in the aforementioned instruments, both national and regional governments be obligated to fulfil SRHR 'progressively', depending on the

⁸ Kenya National Commission on Human Rights (KNCHR) (April 2012): A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya

available resources. This requires it to demonstrate ‘measurable progress towards the full realisation of the SRHR and to desist from adopting regressive efforts.

3.3.5 Degree to which disaggregated data is collected, analysed and reported by the Ministry of Health, Kenya National Bureau of Statistics or any similar reputable source in Kenya.

Available and credible sources of information being used by National government, County government and development partners for purposes of development planning and policy formulation show very limited degree of data disaggregation that reflects how survey findings presents circumstances of different categories of population, especially minority groups and people living with disability. Examination of some of the reputable reports like the Population and Housing Census, Kenya Demographic Health Survey, Kenya Aids Indicator Survey among others, reveal that the level of data disaggregation is largely reported by age group, gender, level of education, region and residence, with minimal if not scanty reporting by disability and minority group. This finding implies that there is a dire need to engage and lobby both national and county government to ensure that they integrate holistic disaggregation of data which reflects circumstances of each category of the population when reporting, including the vulnerable groups. This can be achieved through enactment of a legal framework or a policy that will compel every state institutions and other stakeholders to maintain a set threshold of data disaggregation whenever they present their reports. One of the key informants had this to say:

“We segregate data in terms of male and female but not in terms of minority group because in Mandera County nearly all the people are considered to be minority compared to the rest of the country. This is the reason why we don’t believe in segregating data by ethnicity, minority or majority groups.”

Key Informant Interview, Civil Society Organization Representative

3.3.6 Planned or likely positive adaptations or data collection exercises that are already in discussion

At the county level the survey did not identify any positive adaptations or data collection exercises that are already in discussion. However, at the national level, Kenya National Bureau of Statistics (KNBS) with support from different stakeholders had already began making efforts of commissioning the next Kenya Demographic Health Survey in late 2019 through early 2020. However, this survey was put on hold due to competing priorities and unforeseen circumstances like the COVID19 Corona Virus Pandemic that has brought both government and private sector operations nearly to a halt. When normalcy will resume to warrant commissioning this survey, it will be critical to engage and lobby relevant government ministries and departments to ensure that the next KDHS survey findings integrates reporting by ethnicity, minority groups and disability among other data disaggregation characteristics.

In addition, the baseline study noted that the Ministry of Health has in place Kenya Health Information System (KHIS) for Aggregate reporting⁹. This system is a platform for collecting, reporting, analysis and dissemination of data on health outcome across the country from the smallest health facility up. At the lowest level, collation and reporting of data is managed by the sub-county health information records officer. This platform has the capability of providing real-time statistics on the indicators being sought for by the survey among others, which can be tracked and reported on real-time basis. However, this platform does not have open access to the general public for ease of information access, despite existence of progressive laws like the Access to information Act (2016)¹⁰, that fosters easy access to government information. To access this portal one must make formal request to Ministry of Health for approval. Such request hangs on discretion of the Ministry to grant access or not. Further, there exists a restriction that governs publication of data and information generated from the portal without the authorization of Ministry of Health.

⁹ <https://hiskenya.org/dhis-web-commons/security/login.action>

¹⁰ <http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/AccessstoInformationActNo31of2016.pdf>

4.0 CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

This Baseline Survey set out to collect, analyse, and report detailed disaggregated evidence on disparities in access to Sexual Reproductive Health (SRH) services and identify reliable national and/or county level statistics against which progress of EQUIP Project can be tracked and reported. Specifically, the baseline study aimed to generate the necessary baseline data for (EQUIP) project which is being implemented in partnership with Health Poverty Action (HPA) and IIDA Women's Development Organisation partners in Kenya.

It has emerged from the baseline survey findings that:

1. There exists very limited degree of data disaggregation that reflects circumstances of different categories of population, especially minority groups and people living with disability;
2. There is lack of a robust County SRHR policies and legal frameworks that promote access and uptake of SRHR services, and are specific to each categories of the population at the county level including minority and vulnerable groups.
3. There is low contraceptive prevalence at the County level which was recorded at (1.9%) among currently married women compared to national figure which was thirty-one times higher at (58.0%).
4. There is low number (36.8%) of women of reproductive age reported to have received at least 4 ante-natal care visits during pregnancy, which is considerably lower than the national rate of (58.0%).
5. There is low number of births reported (38.7%) to have been delivered by a skilled birth attendant (nurses, midwives or doctors) compared to (61.8%) at the national level.
6. Over (90.0%) of the surveyed respondents reported that: (i) the service provider explained things clearly, (ii) the service provider showed respect to them and (iii) they were satisfied with the SRH service received.
7. There are no apparent examples of past successful or likely successful SRH policy change processes that have taken place at the County level.
8. The institutional framework for dealing with FGM/C in the County remains feeble – fostering weaknesses in implementation of policy and enforcement of laws that promote access and uptake of SRH services;
9. There exist deeply rooted cultural and religious underpinnings on SRH that hinder access and uptake of SRH services.
10. There is weak health system and long spans of marginalisation that has resulted to limited access to quality maternal health services, including ante-natal, delivery, and post-natal services among others.

11. There exist socio-economic issues like insecurity, long distance to a health facility, and cost of contraceptive services that has hindered many patients from accessing SRH services.

The above key issues combined, present considerable challenges to efforts and interventions aiming to work with duty bearers and right holders towards promoting access and uptake of SRH services in Mandera County. Consequently, the baseline survey is of the view that due to the aforementioned findings, actualizing implementation of activities that have set out to be implemented within the project will be daunting task that might accrue limited outputs and outcomes. Therefore, for the project to realize its aim and objectives, it should seek to pursue strategic partnerships and implementation approaches that will require limited resources and time to implement, with the main aim of achieving substantive outputs and outcomes.

4.2 Recommendation

Moving forward, this Baseline Survey urges in the form of recommendations, that EQUIP Project considers the following:

1. Pursue strategic communication and engagement of clan elders and religious leaders to set off conversations towards changing cultural norms and practices that hinder access and uptake of SRH services.
2. Leverage young (women/men) for change and target them with strategic communication, education and engagement on the benefits and negative implications of not taking up SRH services.
3. Pursue public education on SRH services and increasing awareness on the benefits and negative implications of not taking up SRH services.
4. Pursue political and opinion leaders for commitment to advocate for law and policy enforcement, resource allocation and public buy-in of efforts to promote access and uptake of SRH services.
5. Strengthen or revitalize existing institutional structures like the reproductive health technical working groups that are promoting access and uptake of SRH services.
6. Support capacity development and institutional strengthening to promote policy implementation and enforcement of the laws and policies promoting access and uptake of SRH services.
7. Further capacity development and support for local organizations – CBOs and FBOs to champion awareness, advocacy and engagements towards promoting access and uptake of sexual reproductive health services.
8. Engage and lobby both national and county governments to ensure that they integrate holistic disaggregation of data which reflects circumstances of different category of the population through enactment of policies, legal frameworks or commitments that will compel every state institutions and other stakeholders to maintain a set threshold of data disaggregation whenever they present their reports.

9. At County level, explore existing gaps in SRHR policies and legal frameworks that can be pursued through lobbying the County Government to enact a model law, policy or program that can be used to bridge the gaps.

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6.0 APPENDIX

6.1 Questionnaires



Final Client Exit
Interview



Final Key Informant
Interview (KII)

Client Exit Interview Questionnaire

Key Informant Interview Questionnaire

6.2 Terms of Reference (ToR)



Kenya EQUIP
baseline study