USAID FROM THE AMERICAN PEOPLE Nawiri

Landscape Analysis and Stakeholder Mapping Report of Turkana and Samburu Counties, Kenya

Individual, Interpersonal, Community, and Structural Influences that Shape Adolescent Pregnancy and Childbearing

August 2021

Landscape Analysis and Stakeholder Mapping of Turkana and Samburu Counties, Kenya

Individual, Interpersonal, Community, and Structural Influences that Shape Adolescent Pregnancy and Childbearing

Award Number: 72DFFP19CA00003
Award Period: October 1, 2019 – September 30, 2024

Prepared for USAID
United States Agency for International Development
Matthew Nims, Agreement Officer
ATTN: Kathleen Hartin
Agreement Officer's Representative
khartin@usaid.gov

Prepared by the Technical Working Group on Community Health Systems for the USAID Nawiri Project

This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents of this report are the responsibility of Mercy Corps and do not necessarily reflect the views of USAID or the United States Government.

Table of Contents

Abbreviations and Acronyms

ANC	Antenatal care
APHRC	African Population Health and Research Center
ARH	Adolescent reproductive health
ASAL(s)	Arid and semiarid land(s)
AYSRH	Adolescent and youth sexual and reproductive health
BDCHA	Bureau for Democracy, Conflict and Humanitarian Assistance
CBO	Community-based organization
CHC	Centre for Humanitarian Change
CHEW	Community health extension worker
CHS	Community health system (or strategy)
CHV	Community health volunteer
DFSA	Development food security activity
FGM	Female genital mutilation
FFP	Food for Peace
FP	Family planning
FRC	Field research coordinator
GBV	Gender-based violence
HCW	Health care worker
HPV	Human papillomavirus
IGA	Income-generating activity
KII	Key informant interview
KNBS	Kenya National Bureau of Statistics
LASM	Landscape analysis and stakeholder mapping
LCRH	Lodwar County Referral Hospital
MPDSR	Maternal and Perinatal Death Surveillance and Response
NGO	Non-governmental organization
PNC	Postnatal care
QRC	Qualitative research coordinator
RH	Reproductive Health
RTI	Research Triangle Institute
SBCC	Social behavior change communication
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
STIs	Sexually transmitted infections
SWT	Samburu Women Trust
UN	United Nations
USAID	United States Agency for International Development

1 Summary

The goal of USAID Nawiri is to sustainably reduce levels of persistent acute malnutrition in Kenya's arid and semiarid lands (ASALs) by transforming systems and building capacities to absorb, anticipate, and adapt to shocks and stresses. In Samburu and Turkana counties, USAID Nawiri is facilitated by a Mercy Corps-led consortium of diverse international and national partners that share a commitment to putting county governments and their citizens in the driver's seat of their journeys to self-reliance. Consortium members include Save the Children, Research Triangle Institute (RTI) International, African Population Health and Research Center (APHRC), the BOMA Project, Centre for Humanitarian Change (CHC), and Caritas Lodwar.

Maternal nutrition is a key determinant of the nutritional status of an unborn child. Pregnancy in adolescents has a grave impact on persistent acute malnutrition for both mothers and their babies, who are more likely to be born with a low birth weight, therefore putting them at higher risk for malnourishment, illness, and death. In addition, uneducated adolescent mothers who have no family planning information, poor health status, and often have less decision-making ability and capacity to care for a baby compared to older mothers are at greater risk for their babies wasting. Hence, pregnancy early in life and motherhood are key drivers of persistent acute malnutrition.

The Northeastern region of Kenya is reported to have the highest proportion (29%) of underweight women of reproductive age (15–49 years old) compared to the national underweight level of 9%. Adolescent girls aged 15–19 years are the most nutritionally vulnerable among this group, with a national underweight level of 17%. In Samburu and Turkana, respectively, 26% and 20% of girls aged 15–19 have begun bearing children. Many of these girls are in customary marriages, though in contravention of legal provisions in the country. While policymakers and program leaders have some understanding of prevailing harmful social and gender norms and their contributions to poor reproductive health outcomes, it is less clear what program activities will be most impactful and sustainable in addressing these norms and improving reproductive health (RH) outcomes for adolescents in the two counties. There is also limited evidence on the most effective entry points to reach adolescents and the most effective interventions to build protective factors that can withstand recurrent shocks and stresses (such as droughts, famine, flooding, human and animal diseases) and sustainably improve reproductive health outcomes. This landscape analysis and stakeholder mapping (LASM) sought to document the various interventions or platforms for activities implemented by county governments, bilateral agencies, NGOs, UN agencies, faith-based organizations (FBOs), civil society organizations, and other stakeholders to address vulnerabilities and build resilience to prevent unintended adolescent childbearing, improve RH outcomes among adolescents, or both.

The LASM for the adolescent study was conducted in May and June 2021 through rapid appraisal meetings with key informants in the two counties; in-depth key informant interviews (50 in

Turkana and 56 in Samburu County) with key stakeholders; and review of relevant program and policy documents. Protocols for prevention of the spread of COVID-19 were observed throughout the process.

The findings indicated that both Turkana and Samburu counties have numerous stakeholder interventions that support adolescents in forging, maintaining, and replicating healthy interpersonal relationships within and outside the household, with the intention of affording them with the life skills, guidance, social capital, protection, and encouragement they require for positive and productive transitions into parenthood, the workforce, and civil society. Some of the interventions attempt to address existing social and gender norms that affect RH outcomes for adolescent boys and girls and unlock opportunities for adolescents to safely realize their potentials and aspirations. However, most of the interventions address only partial aspects of adolescent reproductive health (ARH). Furthermore, these efforts and monitoring of their impact are not well coordinated. While formal institutions such as the community health system (CHS) and various pertinent government departments are in place, they have limited personnel capacity and lack collaborative approaches. In addition, national policies have not been fully domesticated. Key factors contributing to pregnancy among adolescent girls in Samburu and Turkana counties include household/family, peers, health system, community (such as harmful cultural norms including female genital mutilation, or FGM, *Moranism*[1], and forced early marriages), and individual- and social-policy related issues. Shocks and stresses which are common in Samburu and Turkana tend to impact adolescent sexual behavior negatively and increase the risks of unintended pregnancies. Utilization of RH services is hampered by lack of knowledge, inaccessibility, stigma, and lack of adolescent-friendly services. While the CHS is well structured, it lacks both the human resources and skills necessary to address ARH needs.

We recommend that both counties be supported to establish government-led multi-sectoral coordination structures at both county and sub-county levels involving ASRH steering committees and technical forums to enhance multi-stakeholder coordination and provide oversight for the domestication of ASRH policies. Facilitation of an initial stakeholder engagement workshop will be key to outline the coordination frameworks and develop their terms of reference. This study identified interventions in both counties that depict near-holistic approaches to addressing ARH issues in the county. We recommend that USAID Nawiri deeply examines the identified interventions for adaptation and scaling up and incorporate robust components of community and parental engagement to improve ARH awareness and possible progressive change of harmful cultural behaviors.

[1] *Morans* are young Samburu men admitted into warrior-hood upon circumcision. **Moranism* – a cultural practice of *Morans* 'booking' young girls who are not eligible for marriage only for sex by buying and giving them beads. The relationship is not aimed at marriage because it happens among clan members (SWT, 2016)

2 Introduction

2.1 Background and Rationale

The United States Agency for International Development (USAID) Nawiri program is a 5-year Bureau for Humanitarian Assistance (BHA) funded development food security activity (DFSA) in Turkana and Samburu counties in Northern Kenya. It commenced in October 2019 and is expected to run through September 2024. The goal of USAID Nawiri is to sustainably reduce levels of persistent acute malnutrition in Kenya's arid and semiarid lands (ASALs) by transforming systems and building capacities to absorb, anticipate, and adapt to shocks and stresses. In Samburu and Turkana counties, a Mercy Corps-led consortium of diverse international and national partners facilitates USAID Nawiri. Consortium members include Save the Children, Research Triangle Institute (RTI) International, African Population Health and Research Center (APHRC), the BOMA Project, Centre for Humanitarian Change (CHC), and Caritas Lodwar.

USAID Nawiri was designed to take a phased approach, in which the first phase is predominantly research oriented. Evidence-based implementation and adaptive programming characterize the second phase. During the first phase of the program, RTI is leading in-depth research and analysis to identify the household and systemic drivers of malnutrition in the two target counties of Turkana and Samburu. Incorporated in the research agenda is the landscape analysis and stakeholder mapping (LASM) on adolescence, focusing on understanding the drivers and mitigating factors of risks and vulnerabilities that lead to unintended pregnancy and childbirth among adolescent girls.

Maternal nutrition is a key determinant of the nutritional status of an unborn child. The Northeastern region of Kenya is reported to have the highest proportion (29%) of underweight women of reproductive age (15–49 years old) compared to the national underweight level of 9%. Adolescent girls aged 15–19 years are the most nutritionally vulnerable among this group, with a national underweight level of 17% (KNBS et al., 2015). Pregnancy in adolescents has a grave impact on persistent malnutrition for both mothers and their babies. The babies are more likely to be born at a low birth weight and are therefore in turn at high risk for malnourishment, illness, and death (WHO, 2016). In addition, the risk of wasting among babies is higher among uneducated adolescent mothers who have no family planning information and poor health status, and who often have less decision-making power and capacity to care for a baby, as compared to older mothers (WHO, 2016). Hence, early pregnancy and motherhood are key drivers of persistent acute malnutrition.

Early adolescence (10 to 14 years old) is a period of major cognitive reorganization and maturation—a window of opportunity for growth and learning with lifelong implications for health and wellbeing. It is a period of increasingly gendered experiences and expectations, which create an opportunity to foster more gender equitable attitudes, behaviors, and norms before negative norms become entrenched (Konrad et al., 2013). Thus, the attitudes, behaviors, and developmental

assets put in place during this time will shape lifelong reproductive and behavioral trajectories. However, young people in the drylands of Northern Kenya contend with harmful occurrences and norms that inhibit their potential, exposing them to vulnerability and risks that lead to poor RH outcomes. In turn, poor RH outcomes exacerbate vulnerability and risk. In Samburu and Turkana counties respectively, 56% and 46% of adolescent girls aged 15–19 years reported having had sexual intercourse (KNBS et al., 2015). Early sexual debut, commonly defined as sex at or before the age of 14 years, is strongly associated with poor health outcomes, such as higher risk for HIV and other sexually transmitted diseases (STIs), unintended pregnancy, sexual violence, and psychosocial stress (Salam et al., 2016). In Samburu and Turkana, respectively, 26% and 20% of girls aged 15-19 had begun childbearing (KNBS et al., 2015). Many of these girls were in customary marriages, though in contravention of legal provisions in the country.

In addition to socioeconomic vulnerabilities occasioned by diverse shocks and stresses that may expose young girls to high risks for sexual abuse and exploitation, violence, and unintended pregnancy, poor RH outcomes among adolescents in Samburu and Turkana counties are rooted in complex sociocultural beliefs and gender inequality at the household and community levels. Early and forced marriage of girls is encouraged as a source of family income and a prestigious way of acquiring wealth. For girls who resist early marriage, parents and community members may condone rape to pronounce her married (Kinaro et al*.,* 2019). In Samburu, youth say that women have no voice or agency, and are considered "children" if they are not circumcised, which refers to female genital mutilation (FGM). Young women in Samburu are also encouraged to have children with multiple partners, which is seen as a protective behavior if the father of their children is killed during conflict (Kinaro et al., 2019). There is also limited use of RH services (i.e., family planning; antenatal and postnatal care; treatment of sexual and gender-based violence [SGBV]; post-abortion care; and prevention and treatment of STIs, including HIV) because of stigma, misinformation around contraceptives, and gender norms. For example, *Morans* (Samburu men in the 'warrior' age group) say they cannot visit a health clinic because they are forbidden to interact with women, while adolescent girls will not visit because they are not supposed to interact with elders (Kinaro et al., 2019). Among the efforts toward reducing persistent acute malnutrition in Kenya's ASALs, USAID Nawiri intends to learn and develop relevant context-specific solutions for improved RH outcomes and healthy, positive transitions of adolescents into adulthood in Samburu and Turkana counties. It is therefore critical to understand the context of efforts in place to address vulnerabilities and risks; build resilience to prevent early, unintended childbearing; and improve RH outcomes among adolescents in the target counties of Samburu and Turkana.

While policymakers and program leaders have some understanding of prevailing harmful social and gender norms and their contributions to poor RH outcomes, it is less clear what program activities will be most impactful to sustainably address these norms and improve RH outcomes for adolescents in the two counties. There is also a gap in evidence about awareness around opportunities and barriers to enforcing the laws and policies that offer protections against the

harmful practices of child marriage and FGM. There is limited evidence on the most effective entry points to reach adolescents and the most effective interventions that will build protective factors that can withstand recurrent shocks and stresses and sustainably improve RH outcomes.

2.2 Purpose and Objectives of the Landscape Analysis and Stakeholder Mapping

The purpose of the LASM was to document and analyze the various interventions or platforms for activities being implemented by the county governments, bilateral agencies, NGOs, UN agencies, FBOs, civil society organizations, and other stakeholders to address vulnerabilities, build resilience to prevent early, unintended childbearing, and improve RH outcomes among adolescents. It also included the review of relevant policies at the national and county levels and relevant program documents (reports, publications, briefs). Its specific objectives were to:

a) Identify innovative and scalable interventions that support adolescents in forging, maintaining, and replicating healthy interpersonal relationships, afford them with the life skills, guidance, and social capital protection they require
b) Identify interventions that address existing social and gender norms that affect RH outcomes for adolescent boys and girls
c) Assess the capacity of formal institutions, inclusive of the community health system (CHS) as a whole, to address gaps around ARH
d) Identify barriers to the full implementation of institutional frameworks (policy, legal) to reduce vulnerabilities for adolescents and youth
e) Identify the main strategic areas of policy that should be put into practice to disrupt the trends in risks and vulnerabilities faced by youth and adolescents

The LASM sought to answer the following questions for the ASAL contexts of Turkana and Samburu counties:

a) What innovative and scalable interventions support adolescents in forging, maintaining, and replicating healthy interpersonal relationships, within and outside the household, and afford them with the life skills, guidance, social capital, protection, and encouragement they require for positive and productive transitions into parenthood, the workforce, and civil society?
b) What interventions can address existing social and gender norms that affect RH outcomes for adolescent boys and girls and unlock opportunities for adolescents to safely realize their productive potential and aspirations?
c) What is the capacity of formal institutions, inclusive of the community health system (CHS) as a whole, to address gaps around ARH?
d) What barriers exist to the full implementation of these institutional frameworks (policy, legal) to reduce vulnerabilities for adolescents and youth?
e) What are the main strategic areas of policy that should be put into practice to disrupt the trends in risks and vulnerabilities faced by youth and adolescents?

3 Methodology

The LASM for the adolescents' study was conducted through rapid appraisal meetings with key informants in the two counties, in-depth key informant interviews (KIIs) with key stakeholders, and review of relevant program and policy documents. Protocols for prevention of the spread of COVID-19 were observed throughout the process.

3.1 Rapid Appraisal Workshops

The objective of the workshops was to identify key stakeholders, agencies, and efforts that have been in place for addressing vulnerabilities and/or building resilience to improve adolescent reproductive health outcomes. One-day rapid appraisal workshops were conducted in each county with key representatives from relevant government sectors, the community, and implementing partners. They were selected based on pertinent contextual expertise and experience, either personal or professional, in one or more of the following areas (see also Appendix 1):

a) Maternal health and reproductive health service provision, including family planning
b) HIV and sexually transmitted infections (STIs) among adolescent girls and young women
c) Adolescent and youth sexual and reproductive health (AYSRH) issues and programming
d) Protection and SGBV issues such as early and forced marriage, intergenerational and transactional relationships with minors
e) Prevailing social gender norms and challenges
f) Demand-driven community-level programming
g) Mental health and psychosocial support
h) Nonclinical aspects of SGBV, such as prevention, legal/reporting, protection, mental health, and psychosocial support, improved wellbeing of adolescents, including but not limited to livelihoods, safe spaces, and skill-building

Table 1 shows the number, affiliation, and designation of the stakeholder mapping workshop participants by county. The list of participants can be viewed in Appendix 2.

Table 1: Participants of Stakeholder Rapid Assessment Workshops in Turkana and Samburu Counties

Department/Sector/Partner	Turkana County (N=23; 7F, 16M)	Samburu County (N=21; 9F, 12M)
	Number Participating in Stakeholder Rapid Assessment Workshops	
Government Departments	4 (1F, 3M)	9 (3F,6M)
Implementing Partners	5 (M)	4 (2F, 2M)
Nawiri	15 (8F, 7M)	8 (4F, 4M)

In groups of five or six people, workshop participants brainstormed and listed key issues impacting ARH, mapping them under the four human development themes of *governance*, *social*, *economic*, and *environment*. Each group presented the issues in the plenary session for discussion and consensus building. Once there was consensus on the issues impacting ARH, each group identified and listed the key stakeholders in the county working to address each issue and mapped their geographic areas of operation within the county. The groups further recommended stakeholders for in-depth KIIs based on their perceived positive influence on ARH and geographic coverage. Each group identified and presented to the plenary a list of stakeholders working to address the identified ARH issues and provided a list of stakeholders they recommended for in-depth interviews for concurrence.

3.2 Participant Identification and Selection

Stakeholders and key informants were identified through rapid appraisal workshops involving small groups of five or six participants considered to have pertinent contextual expertise and experience in the counties. They constructed relevant lists that revealed various categories of actors, including community health units, community-based organizations (CBOs), faith-based organizations (FBOs), bilateral agencies, NGOs, UN agencies, and government sectors at national, county, sub-county, ward, location, and village levels. A prior stakeholder scoping exercise had indicated that there could be more than 90 relevant stakeholders working on ASRH issues in each county. A total of 62 Turkana and 82 Samburu potential KI respondents were identified and listed during the rapid appraisal workshops. We purposely targeted a goal of at least 40 KIIs per county, to cover a wide range of relevant stakeholders and interventions and represent all the geographical regions within the counties. Due to the range of stakeholders implementing diverse activities and significant geographical differences in the counties, early information saturation was not anticipated. We conducted 50 and 56 KIIs for Turkana and Samburu counties, respectively. Table 2 shows the number of stakeholders recommended for in-depth interviews and the actual number interviewed, by county. The detailed lists of stakeholders recommended for in-depth interviews are presented in Appendix 3.

Table 2: Key Informants Covered

Department/Sector	Turkana County		Samburu County	
	Number of Stakeholders			
	Listed	Interviewed	Listed	Interviewed
Government sectors				
● County level	11	9	17	9
● Sub-county and ward levels	14	15	21	13
UN and bilateral agencies	2	-	3	2
Implementing partners	9	5	18	11
Faith-based organizations	4	4	1	1
Youth councils, networks, and centers	6	4	-	
Community-based organizations	9	6	8	5
Community units and resource persons	7	7	14	15
Total	62	50	82	56

3.3 Data Collection

Data collection activities were undertaken in the months of May and June 2021.

3.3.1 Training of Research Assistants

The USAID Nawiri team developed and reviewed two KII guides—one for county government sectors and implementing partners and the other for sub-county and community-level stakeholders. The sub-county and community-level stakeholders KII guide was translated to Swahili. This was followed by a two-day training of research teams for each county on how to conduct the KIIs using the tools provided, label interview recordings, and prepare daily KII debriefs. The trainings also included coaching of the research teams on COVID-19 protocols, as well as pre-testing and revision of tools based on the pre-testing feedback. The teams included six research assistants per county, who conducted the KIIs, and USAID Nawiri and county government staff that provided data quality assurance oversight and booked appointments with relevant key informants. Table 3 shows the persons who participated in the training by county.

Table 3: Participants in the Research Assistants Training

Participants	Turkana County			Samburu County		
	Male	Female	Total	Male	Female	Total
Research assistants	3	3	6	3	3	6
Government departments	1	-	1	2	2	4
Youth representative	1	-	1	-	-	-
Nawiri	6	2	8	4	2	6
Consultant	-	1	1	-	1	1
Total	**11**	**6**	**17**	**9**	**8**	**17**

3.3.2 Data Collection Tools

Pre-tested KII guides were used to solicit information on key factors associated with adolescent pregnancy and reproductive health behaviors; interventions; and activities of government and non-government stakeholders (agencies and departments), including policies, strategies, and programs addressing ARH issues in the focus counties. The tools covered the following thematic areas:

a) Key factors contributing to adolescent pregnancy and SRH behaviors
b) Adolescent responses to household shocks and stresses
c) Adolescent utilization of RH services
d) Stakeholder awareness of key policies, strategies, and interventions that support ARH
e) Initiatives, programs, and projects implemented in the focus counties that address issues related to adolescent pregnancy
f) Capacity of the CHS to address issues around ARH

3.3.3 Data Collection Methods

The identified key informants were distributed among three teams each comprised of two trained research assistants. Data collection involved a mix of face-to-face and virtual interviews via the Zoom platform with a trained interviewer and a note taker. In addition, audio recordings of the interview sessions were made.

3.3.4 Data Quality Controls and Management

The research assistants summarized KII responses by question into debriefs and electronically transmitted them to the field research coordinators (FRCs) who checked them and uploaded them to a shared folder that was accessible to the research team. In instances where the FRCs were not able to access the Internet, they transmitted the debriefs to the research and design specialist or/ and the qualitative research coordinator (QRC), who then uploaded them to the shared folder. To eliminate confusion, they ensured congruent naming of debriefs and labeling and tagging of audio recordings.

3.3.5 Data Analysis

All audio recordings were transcribed verbatim and translated into English. The transcripts were coded for thematic analysis based on a previously prepared codebook. Coding was done per question in NVivo Software.

4 Findings

4.1 Key Factors Contributing to Pregnancy and Reproductive Health Behaviors Among Adolescent Girls

The KII findings depicted similar types of factors contributing to adolescent pregnancy and adolescent sexual and reproductive health behaviors in both Turkana and Samburu counties. The factors were classified as household/family, peer-related, health system, community, and individual and social policy.

Household/Family Factors

The household issues presented from the findings included poverty, insufficient parental care and guidance, lack of good role models, and the negative perceived value of educating a girl-child at the family level.

The poverty rate was reported to be high in both counties (60% in Samburu and 66% in Turkana) which negatively impacts households' ability to meet basic needs, including food, clothing, and adolescent girls' supplies, such as sanitary towels. According to a senior government officer in Turkana County: *"Poverty index in Turkana is high, making it one of the top driving forces for adolescents to engage in early sex, leading to unintended pregnancies."* In Samburu County, a key informant from an implementing non-governmental stakeholder expressed: *"Poverty is a contributing factor. You will find a girl is not of marriage age, about 13–14 years, and she has no access or has no money to buy undergarments or sanitary towels. So, in that state men take*

advantage of her and defile her for money, and the outcome is pregnancy." When their basic needs are not met, young girls from poor households tend to drop out of school and are likely to engage in sexual activities or early marriage, resulting in adolescent pregnancy. They may also engage in transactional sex as a means of fending for their basic and sanitation needs, as expressed by one youth representative in Turkana County: *"Adolescents have many needs, and as a result, they engage in sexual activities and unknowingly get pregnant."*

Insufficient parental care and guidance was associated with inadequate engagement of parents with their children due to the lifestyle of parents and the tendency of parents being wary to talk about sex with their children. For instance, it was indicated that pastoralists tend to leave their children with relatives, while working urban parents leave them with other people who are not keen to supervise or engage the children on sex issues. A community health extension worker (CHEW) in Turkana County remarked: *"I have never seen them educate or giving guidance and counseling to the girls on how to handle shocks and stresses, and as you know, education is power."*

While economic activities are meant to provide for families' financial needs, *"Some of the economic activities conducted by parents like alcohol brewing makes the girls prey to the customers there,"* said a county government officer. Some families brew and sell alcohol for a livelihood in Samburu North and in parts of Turkana Central, West, North, and Loima sub counties. Apart from falling prey to customers, adolescents in such families are likely to abuse the local brew and engage in sexual activities. Ignorance and high levels of illiteracy in both counties were mentioned as key hindrances to parental engagement. It was also noted that information about sex was not discussed openly, and parents especially hindered adolescents from accessing this knowledge. *"The community tends to be very shy in talking about sex … they don't get any advice from the family… and that lack of sexual knowledge contributes to early pregnancies,"* said a key informant from an implementing partner in Samburu County. "*Some parents don't talk to their children about what to expect when transitioning to adulthood and its pitfalls,"* voiced a senior county government officer in Turkana County.

The lack of good role models in the family and in the community was reported to also contribute to adolescent pregnancy and sexual and reproductive health behaviors. Due to high illiteracy rates and low school enrollments, many school-going children in the focus counties lack role models they can look up to. In addition, it was noted that many of the mothers were also teenagers when they had children, and this makes it difficult for them to be role models for their own adolescents.

Attending school for adolescent girls is regarded as a protective mechanism against engaging in sexual activities. Nonetheless, community-level key informants in Turkana and Samburu counties indicated that both communities consider it more valuable to educate a boy-child than a girl. Since the girl will eventually be married off to another family, her education is not considered to be of value to her biological family; hence girls are not educated, but rather engaged for marriage at an early age.

Peer Factors

Peer pressure was identified as a driver of pregnancy and reproductive health behaviors among adolescents in both Turkana and Samburu counties. A key informant from a government department in the Ministry of Education in Turkana County said, *"…adolescents like to try new things, hence during their interaction as peers, they influence one another to try out various experiences including use of alcohol, drugs, and sex…"* This puts the girls at risk of early pregnancy.

In Samburu County, social practices, such as after-circumcision night dances of *Morans* with young girls, escalates the risk of adolescent pregnancies.

Health System Issues

Long distances to health facilities, unavailability of services and commodities, and the absence of youth-friendly/responsive health facilities and services also negatively impact uptake of SRH services and contribute to increased pregnancy among adolescents. Some health facilities are not opened on all days and do not always have RH services and commodities. Negative attitudes towards adolescents by some HCWs and costs attached to RH services were also indicated to negatively affect SRH services. Other health system issues included the lack of training of some HCWs to provide youth friendly SRH services and a language barrier among some HCWs who come from outside of the community. Furthermore, some adolescent girls fear being attended to by male HCWs while others prefer being attended to by someone closer to their age.

Community Factors

Harmful cultural beliefs and practices were revealed as key contributors to adolescent pregnancies in both Turkana and Samburu counties. In Turkana County, girls are perceived as sources of wealth and are forced out of school by their fathers into early marriages for their dowry. A facility health care worker remarked: *"Girls are believed to be a source of wealth and are forced into marriages at a tender age."* A CHEW in the same county observed, *"The culture allows parents to wed their children off to older men despite being underage. They get forced into early marriages. Even here in the MCH, we get little girls who tell you they had men forced on to them*."

In Samburu County, it was noted that the cultural practice of girl-child-beading validates a nonmarital sexual relationship between *Morans* and young Samburu girls (usually 9–15 years old) who are not yet eligible for marriage. It involves the *Morans* giving specialized beads to an uncircumcised girl to signify the commencement of a sexual relationship. This cultural practice is of great concern among the administrative leaders. *"We have these cultural practices which are not good at this time, of Moran groups, beading of girls, that is, just like temporary wife. In the process we get early pregnancies,"* said a Chief in Samburu County. In addition, once an adolescent girl undergoes FGM, she is perceived as a grown woman who is ready for sexual activity and marriage. A key informant from one of the CBOs in Samburu County stated *"…cultural practices like FGM, early marriages are other factors contributing to early*

pregnancies. For example, once a young girl undergoes the cut she is perceived as an adult person so now even old men can marry her or have sexual encounter with her." After undergoing FGM, most of these young girls subsequently drop out of school and are married off. Some parents force their girls to undergo FGM and then into early marriage.

Due to the communities' cultural sexual practices, SGBV against young girls such as rape, defilement, and coerced sex take place unabated, leading to unwanted and early pregnancies. The limited safe spaces for adolescent girls to retreat and learn and the lack of support for girl-child education leaves them vulnerable to these practices and their effects.

Social Policy Issues

Some of the social policies that were created to address ASRH were viewed as promoting or condoning indulgence in sexual activities by adolescents. For instance, some key informants perceived that the Ministry of Education law that allows re-enrollment of girls in school after childbirth could promote adolescent indulgence in sexual acts. Other issues mentioned included limited coverage of important aspects such as adolescent RH guidance and counseling when household shocks and stresses occur, such as the ongoing COVID-19 pandemic.

Individual Factors

Reported individual factors that contribute to adolescent pregnancy and SRH behavior include exposure to and indulgence in substance abuse, including alcohol; media and technology influence where adolescents are exposed to pornography; and lack of engagement in meaningful activities (idleness). It was also noted that ignorance and lack of awareness about SRH services, unprotected sex, and decay in morals are some of the key individual-level factors contributing to adolescent pregnancies in both Turkana and Samburu counties.

Table 4: Summary of Key Factors Contributing to Adolescent Pregnancy and Reproductive Health Behaviors in Turkana and Samburu Counties

Category of Factors	Means of Contribution to Adolescent Pregnancy
Household/family factors	Poverty ● Lack of basic needs—food, clothing, hygiene ● School dropouts ● Engagement in transactional sex Insufficient parental care and guidance ● Weak parental engagement and communication on sex and reproductive health ● Parental lifestyles and behavior
	Lack of good role models ● Uneducated older population ● Parents who were teenagers when they had children
	Perceived value in educating the girl-child ● Preference to educate the boy-child ● Age
Peer issues	Peer influence/pressure Risky social practices, e.g., night dances of *Morans**with young girls
Health system issues	Lack of/limited access to appropriate RH information services ● Proximity to health facility (county vastness) ● Lack of youth-friendly RH services ● Unavailability of RH services ● Limited and inappropriate knowledge of RH service and rights
Community factors	Harmful cultural beliefs and practices ● *Moranism* and girl-child-beading in Samburu County ● FGM and early, forced marriages in both Samburu and Turkana counties ● Girls perceived as sources of wealth and engaged for marriage at an early age
	Sexual and gender-based violence ● Rape/defilement ● Coerced sex
	Limited safe spaces for adolescents to retreat and learn
Social policy issues	Formulation of social policies ● Affirmative action policies are perceived to promote adolescent indulgence in sexual activities ● Limited coverage of important aspects, such as adolescent RH guidance and counseling ● Limited coverage on counteracting effects of shocks and stressors on adolescence, e.g., long periods of school closures (COVID-19) resulting in idleness, school dropouts

Individual factors	• Substance abuse • Media/technology influence • Not engaging in meaningful activities (idling) • Ignorance and limited knowledge on SRH, • Unprotected sex • Lack of morals and arrogance

4.2 Adolescent Responses to Household Shocks and Stresses

During the KIIs, interviewers sought information on how adolescents respond to household shocks and stresses, such as drought, floods, locust infestation, lack of security, and disease outbreaks such as COVID-19. It was noted that depending on the social and economic environment of the individuals, adolescents respond in different ways. Three thematic areas of adolescent response to household risks and stresses were elucidated.

Increased participation in risky and negative behavior: Some adolescents respond to household shocks and stresses by indulging in sex, substance abuse, crime, violence, night parties or discos, early marriage, and early entry into the labor force (child labor). Adolescents may engage in sex for various reasons: transactional sex, to meet their needs; due to the influence of drugs and alcohol consumed out of idleness; or due to increased interactions with peers and other community members. *"Some will engage in transactional sex with older men to sustain and meet their needs,"* said a key informant among implementing partners in Turkana County. Indulgence in substance abuse, crime, violence, and night parties stems out of frustration, idleness, and lack of supervision while parents are busy addressing the shocks and stresses. The effects of such behaviors include unintended pregnancies among adolescent girls, and proliferation of STIs. Stressors also created conflicts, for example, droughts caused arguments over water and pasture among *Morans* in Samburu County.

Increased involvement in positive activities: When confronted with household risks and stressors, positive activities include: helping with household chores, herding, supporting peers with schoolwork, peer-to-peer social engagements, and innovative social actions, such as participating in agricultural or sports youth clubs. Some formed groups to do income generating activities (IGAs) such as kitchen gardening to keep themselves busy.

Psychosocial distress: The pressures of household shocks and stresses may result in mental distress or ill health, either directly or because an individual engages in some of the risky negative behaviors listed above. For instance, stress could lead to substance abuse, which could lead to unprotected sex resulting in unintended pregnancy, which in turn subjects the affected adolescent to psychosocial distress.

4.2.1 Effect of Shocks and Stresses on Adolescent Interpersonal Relationships

The findings indicated that household shocks and stresses have both positive and negative effects on adolescent interpersonal relationships with their peers, parents, and other people in the community.

Relationships with peers: Some adolescents take positive actions, including seeking social support and security among peers or responsible people in the community, such as religious and administrative leaders. They engage peers in positive social activities like sports, music, and religious events. Nevertheless, a substantial proportion of adolescents in the focus counties experience negative effects of shocks and stresses on their interpersonal relationships with peers. Many engage in risky behavior as described above. Others form undesirable groups and lure or encourage their peers to participate in risky actions such as stealing and banditry, alcohol, and drug abuse. When the girls get unexpectedly pregnant, some are stigmatized, segregated, and become withdrawn

Relationships with parents: Shocks and stresses expose adolescents to different experiences in their relationships with parents, depending on how both the parents and the adolescents cope with the pressure. When there is good communication and engagement, the adolescent learns resilience from parents. In some cases, the relationship is improved because of more positive interactions in dealing with the shocks. However, environments with poor engagement and understanding between adolescents and parents during shocks and stressors result in defiance, rebellion, and possible separation. In addition, separation is also caused by parents marrying off their children for dowry to sustain the family's basic needs during shocks and stressors, or due to the girls getting pregnant after engaging in sex to sustain basic needs. Conflict between adolescents who engage in risky behaviors because of parental disapproval and their parents also increases.

Relationships with other people in the community: In Samburu County, shocks and stresses were reported to stimulate collective responsibility and caused adolescent peer groups to engage in community services. It also creates community cohesion as the youths take up responsibility at the community level. According to a community elder from Samburu North:

> "*Those adolescents are the ones needed in the community when there are problems, they are the security, the workforce, they are the ones to be sent somewhere if there is an issue… if there is something that requires them to be together and there is a way to bring them together, they will help the community in so many ways."*

On the other hand, the deleterious effect of shocks on the needs and normal lives of young people leads them to indulge in adverse actions, such as increased theft in the community, which results in conflicts with other people. Others may be sexually exploited, get pregnant, and become stigmatized and viewed negatively in the community. Young people from very poor families that resort to begging may be shunned and, in many cases, segregated. This was underscored by a government sector key informant from Turkana County: "*Some households resort to borrowing foods from other households, and are branded as beggars, which affects how the child behaves to others.*"

Some of the shocks, such as insecurity, result in reduced social gatherings for information and education of the adolescents.

4.2.2 Influence of Adolescent Social Connections and Interpersonal Relationships on Their Response to Shocks and Stresses

Social connections with peers: When adolescents have interacted, cooperated, and come together for activities with each other and their community, they pool together to counter shocks and stresses when they happen and develop resilience for themselves and as a community. When this is not the case, they experience psychosocial stress and respond negatively by engaging in risky sexual behavior, suspicion and conflicts, poor social practices, and isolation.

Social connections with parents: Good relationships with parents cushion adolescents against adverse responses to shocks and stresses. They endeavor to unite with their parents to find solutions, bringing about family cohesion. *"Those close to their parents understand and become more proactive than reactive than those who have no idea, move blindly, and get into problems,"* a senior county government officer stated. When relationships with parents are weak and poor, there is increased parent-child conflicts, trauma, and parent-child separation.

Social connections with other people: If there is social disconnect with the adolescent due to negative community perception, the adolescent is likely to experience social stigma and will not feel comfortable to seek assistance or services from other people during shocks and stress. Adolescents who have good connections with people and relatives with good social and moral standing can find fortification in times of shock and stress.

4.2.3 Influence of Shocks and Stresses on Adolescent Sexual Behavior

Shocks and stresses were reported to influence adolescent sexual behavior in various ways. In most cases, long droughts rob both pastoralist and agro-pastoralist households of their livelihoods, resulting in poverty. In turn, this leads to strained and broken relationships when parents are unable to meet the basic needs of their adolescent children. In situations without parental supervision and care, when trying to deal with the pressure resulting from increased poverty, some young people resort to alcohol and drugs, increasingly engaging in risky sexual behaviors while under the influence. Others indulge in transactional sex to address basic needs, such as food. Referring to the way local public transport operators take advantage of needy girls, an Assistant Chief in Turkana County disclosed: "*Motorbike riders and Probox drivers trap girls by gifting them with shoes or other small necessities for sexual intercourse resulting in pregnancy."* Another key informant in Turkana County stated: *"The challenges are compounded with food insecurity. As adolescent girls look for money through sex, to sustain their families."*

In some cases that negatively affect household resources (e.g., drought) or result in forced school closures (e.g., floods or the COVID-19 pandemic), adolescents remain idle at home, which increases their indulgence in sexual activities. However, in times of great hunger, sexual activity among adolescents is reported to be low because the body is generally lethargic.

4.3 Adolescent Utilization of Reproductive Health Services

The findings demonstrate that some adolescents utilize reproductive health services in the focus counties of Turkana and Samburu. This inquiry did not explore the extent to which the services are utilized by adolescents. Figure 1 shows the RH services commonly used by adolescents in the two counties, which include family planning resources (condoms and Depo-Provera injection - all cited by about 75% of KIs); morning after pills (cited by about 33% of KIs); antenatal care (ANC) services; postnatal care (PNC); post-rape care services (treatment, guidance, and counseling); and health education.

In Turkana County, it was indicated that some adolescents underwent testing for HIV and HPV screenings, while in Samburu County, adolescents underwent SGBV education.

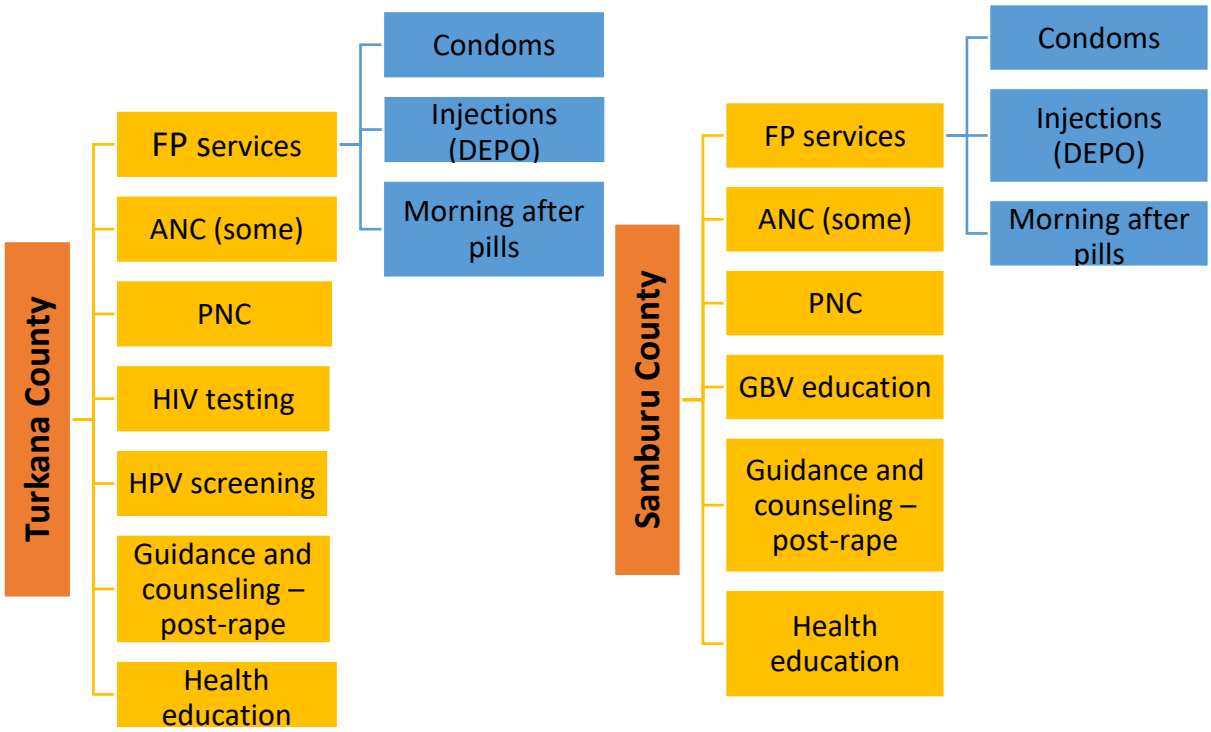

Figure 1: Reproductive Health Services Commonly Used by Adolescents in Turkana and Samburu Counties

4.3.1 Key Barriers to Adolescent Access and Uptake of Reproductive Health Services

Five barriers to adolescent access and uptake of reproductive health services were identified, namely: service access and provision, individual, community, family, and environment. Table 5 summarizes the types of barriers and the specific issues associated with them.

Some adolescents have a fear of visiting health facilities, due to expected stigmatization based on community perceptions of adolescent sex and the use of resources like contraceptives. In Samburu

County, some communities associate use of contraceptives with promiscuity. In Turkana County, pregnant adolescents fear accessing RH services because of the associated shame. This issue is compounded by the lack of adolescent safe space and youth-friendly services at health facilities and in the community. Given the vastness of the counties, individuals often must travel a long distance to the nearest health facility; poor infrastructure of roads makes it difficult for young people to access health services. Other issues of service access and provision include limited awareness or information on RH services, lack of confidence in health care workers (HCWs) maintaining confidentiality, poor attitude, and capacity of HCW, unavailability of services and/or stock-out of contraceptives, and service fees.

Individual barriers include issues of ignorance or lack of knowledge, illiteracy, fear, and peer pressure. Community, family, and environmental issues are as shown in Table 5.

Table 5: Summary of Key Barriers to Adolescent Access and Uptake of Reproductive Health Services in Turkana and Samburu Counties

Type of Barriers	Specific Issues
Services access and provision	• Stigma: afraid to be seen visiting service points, fragmented services (e.g., visiting a family planning (FP) clinic which is not integrated with other services associated with promiscuity) • Lack of adolescent safe spaces and youth-friendly services • Distant health facilities and poor infrastructure • Limited information on RH; limited awareness creation • Fear of service providers breaching confidentiality, especially if tested for HIV • HCW attitudes toward adolescents • HCW capacity (both competence and volume) to provide adolescent and youth-friendly reproductive health services • Unavailability of services and commodities (stock-outs) • Service fees (where they charge for services)
Individual	• Fear and stigma • Ignorance or lack of knowledge and awareness • Illiteracy • Peer pressure

Community	• Nomadic lifestyles
	• Ignorance
	• Cultural beliefs and practices
	  o Samburu *Moran* consider going to a health facility a sign of weakness
	  o Use of traditional birth attendants and traditional herbs
	• Myths and misconceptions, especially concerning FP

	• Community-instigated stigma
	  o Societal judgment
	  o Gender of service providers
	• Some religious beliefs

Family	• Poor awareness • Lack of support • Poverty
Environment	• Insecurity • Natural calamities, shocks, or stresses

4.3.2 Main Sources of Health and Sex Education for Adolescents

The reported main sources of health and sex education for adolescents in the two counties are shown in Table 6. The community health system, health talks during barazas and chemists/drug stores were mentioned as sources of health and sex education for adolescents in Samburu and not Turkana County. This could be because this question was asked to only a small proportion of the respondents in Turkana County.

Table 6: Main Sources of Health and Sex Education for Adolescents in Turkana and Samburu Counties

SAMBURU COUNTY		TURKANA COUNTY	
Source of Health and Sex Education	**Method of Delivery**	**Source of Health and Sex Education**	**Method of Delivery**
Non-governmental organizations	Organized mentorship seminars, peer education, and outreach services	Religious institutions	Health talks in religious youth camps by invited professionals
Schools/learning institutions	Public health talks, school health clubs, and programs	Schools/learning institutions	Public health talks by professionals from the Department of Public Health
Media	Videos and other media channels	Media	All media channels
Health facility	Health talks and counseling sessions	Health facility	Health talks and counseling sessions
Community health system	Community health volunteers who have been trained to provide health and sex education		

	to adolescents in their community units		
Open barazas and political meetings	Health talks during youth political meetings or barazas		
Chemists/drug–selling points	Questions answered when adolescents visit for supplies		

4.4 Policies, Guidelines, Strategies, Frameworks, and Interventions Supporting Adolescent Reproductive Health in the Focus Counties

Key informants from relevant county government sectors and key implementing partners were asked about their awareness of the existence of key policies, guidelines, strategies, frameworks, and interventions supporting ARH in the respective counties.

Table 7 shows the list of key policies, guidelines, frameworks, and strategies identified by some of the stakeholders. Most of the stakeholders were not aware of the relevant key policies, guidelines, frameworks, and strategies at county and national levels. For instance, of the interviewed stakeholders in Samburu County, 23% could name one policy, 50% could name 0 and 27% could name two. In Turkana County, the respective proportions of stakeholders were 14.3%, 71.4% and 14.3

It is evident from Table 7 that there has been more effort to domesticate relevant national policies and guidelines in Samburu than in Turkana, though some were yet to be validated, such as the Samburu County Anti-Beading Policy, the Samburu Gender Policy and the Samburu County Adolescent and Youth-Friendly Services Policy all drafted in 2019/2020. The Covid 19 pandemic contributed to the slow validation process. The drafting of the policy in Samburu was supported through funding the Youth in Action (Y-act) project implemented by Amref-Health and whose mandate is to address challenges prioritized by youth. Turkana county does not have a similar initiative and hence has fewer adolescent and youth related policies.

Table 7: Key Policies, Guidelines, Frameworks, and Strategies Identified by Government and Implementing Partner Key Informants in Turkana and Samburu Counties

Turkana County	Samburu County
Identified Policies, Guidelines, and Frameworks	
● National ASRH Policy of 2015 ● National Guidelines for Adolescent and Youth-Friendly Services 2016 ● Nurturing Care Framework ● Ending Drought Emergencies –Elaborate framework ● Menstrual Health Policy ● County Nutrition Action Plan ● Adolescent – Youth Sexual County Guidelines ● County Child Protection Strategy	● National ASRH Policy of 2015 ● National Guidelines for Adolescent and Youth-Friendly Services 2016 ● Kenya Maternal and Perinatal Death Surveillance and Response (MPDSR) guidelines, 2016 ● Kenya Health Policy ● Reproductive Health Policies ● County Nutrition Action Plan ● Adolescents and Gender Transformative Toolkit (Afya Timiza) ● Adolescents and Youth Social and Behavior Change Communication (SBCC) materials ● Anti-beading policy (Y-ACT) ● Samburu County Adolescent and Youth-Friendly Services Policy (in draft)
Identified Strategies and Interventions	
● Adolescents and Youth Social Behavior Change Communication Strategy ● Adolescents TV program ● Provision of dignity kit and RH information ● Cash transfer program ● AICH Health Program ● Key Populations Strategy ● Outreach-based Strategy ● Linda-Mama Model ● Communication Strategy for the Adolescents (Afya Timiza) ● Adolescent Health and GBV Program	● Mother-To-Daughter forum and Father-To-Son forums by Amref Health Africa ● Adolescents and youth sexual reproductive health services strategy ● Reproductive health digital platform intervention ● Livelihood intervention ● Capacity-building strategy ● Religious organization initiatives ● Uzazi Salama–Biotisho ● AFYA Timiza–Ngaemuenisho and Manyoto; Vijana Tuchangamke ● Youth in Action (Y-ACT) Program intervention ● Moonlight strategy ● Samburu County adolescent and youth nutrition strategy ● AMURT Resilience and Education Program ● Reproductive health strategy for school

4.5 Interventions Addressing Adolescent Reproductive Health Issues

We identified numerous interventions and platforms for activities being implemented to address vulnerabilities and build resilience to prevent early, unintended childbearing and improve RH outcomes among adolescents by county governments, bilateral agencies, NGOs, UN agencies,

FBOs, civil society organizations, and other stakeholders. The detailed lists, though not exhaustive, of specific interventions that were ongoing or completed within the immediate past three years are presented in Attachments A and B. The implementation of the interventions was spread over different geographical areas of the counties. However, there was no clear coordination framework, structure, or mechanism of these efforts in both counties.

Some of the interventions illustrate ingenuity and potential for supporting adolescents to forge, maintain, and replicate healthy interpersonal relationships within and outside the household, and/or afford adolescents with the life skills, guidance, social capital, protection, and encouragement they require for positive and productive transitions into parenthood, the workforce, and civil society. These are summarized in Tables 8 and 9. It is worth noting that the strengths, weaknesses, and opportunities presented in the tables were limited to responses from key informants. It was not possible to access project documents for details.

Table 8: Potential Innovative and Scalable Interventions Targeting Adolescent ARH Issues in Turkana County

Serial Number	Description of Initiative/Project	Key Activities of the Initiative/Project	Weaknesses	Strengths and Opportunities
1	**Name**: Turkana County Youth Program **Organization**: Ministry of Trade, Youth and Gender **Duration**: 2015–ongoing **Coverage**: Turkana County **Target Group**: 18–35 years old **Goal:** To improve adolescent and youth economic stability	● Creating awareness about the youth loan facilities and opportunities ● Formation and training of youth groups ● Establishing an economic program to improve access to affordable loans aimed at increasing access to quality food, which ultimately improves health ● Addressing economic instability intending to improve access to quality food	● Targets youth aged 18 years and older and leaves out younger adolescents ● Focus is skewed toward loans and economic stability	● Founded in a county government sector, which can promote sustainability ● Has potential to be adapted for younger out-of-school adolescent groups, integrating RH and life skills interventions ● Has potential for countywide coverage
2	**Name**: Teenage mothers' program **Organization**: Catholic Diocese of Lodwar, Turkana County, Gender and Child Protection Network **Duration**: 2018–2021 **Coverage**: Turkana County **Target Group:** 15–19 years old **Goal:** Re-enrollment of girls in school and provision of psychosocial support	● Education and school re-enrollment support to teenage mothers ● Provision of dignity kits ● Provision of psychosocial support to teenage mothers	● Focused only on teenage mothers	● Provided needed psychosocial support to teenage mothers ● Had potential for enforcement of legal redress
3	**Name**: School health program – Organization: Afya Timiza–Amref	● Liaise with the Ministry of Education; visited schools to give health education on	● ARH education is not fully incorporated in	● A multisectoral and collaborative approach

	Health Africa and Department of Public Health **Duration:** 2019–ongoing **Coverage:** Lokichar Ward **Target Group**: 12–15 years old **Goal:** To reduce early and unexpected pregnancies and early marriages among youths and teenagers and ensure that they are in school	SRH and FP and establish condom dispensers at strategic points to improve access ● Addressed stigma to encourage youths who need family planning services to go to facilities	the school guidance and counseling guide ● Program was implementing partner driven and required facilitation support by relevant government sectors	● Had potential to strengthen school health programs ● Potential to reach parents and address harmful cultural practices ● Has potential to keep adolescents in school and incorporate a component to reach those out of school; advocacy for education
4	**Name**: Healthy Choices for a Better Future: My Health My Choice; Sister to Sister; Shuga **Organization**: World Vision **Duration**: June 2021–July 2023 **Coverage:** Turkana County, except Kibish Subcounty **Target Group**: 10–24 years old, with a bias to adolescent girls **Goal:** Ensure adolescent access to essential services of biomedical behavioral and structural interventions to reduce their vulnerability to HIV infections; and improving the access of SR Services	● Creating awareness of HIV and AIDS ● Integrated community outreaches ● Sensitizing community leaders, community members, and the young people on cultural norms (social mobilization and norms change) ● Supporting cash transfer programs for adolescent girls and young women ● Vocational training for girls and life skills and mentorship programs for adolescents and youth in the community ● Economic empowerment of adolescent girls and young women	● Implementing partner driven	● An integrated approach that not only addresses adolescents, but incorporates communities to address cultural issues ● Has room to integrate school-based approaches as well as arts, sports, and youth-friendly services

5	**Name**: SRH Program **Organization**: Save the Children **Duration**: June 2018–July 2020 **Coverage**: Turkana Central and South **Target Group**: 10–24 years old: girls and young women **Goal**: Reduce HIV/AIDS among adolescents and young women	● Supported demand generation and access to ASRH services ● Supported SRH school-based activity through manual development ● Established a youth center ● Advocacy and policy formulation ● Established a youth-friendly center to enhance assessment of AYSRH services ● Supported dissemination of youth-friendly age-appropriate services, including counseling, ANC, and HIV services in the youth-friendly service center	● Implementing partner driven	● Addressed the whole spectrum of ASRH, ranging from policy formulation to demand generation and access to services ● Design has potential to incorporate a multisectoral approach for ownership and sustainability

Table 9: Potential Innovative and Scalable Interventions Targeting Adolescent ARH issues in Samburu County

Serial Number	Description of Initiative/Project	Key activities of the Initiative/Project	Strengths and Opportunities

1	**Name**: Binti Shujaa **Organization**: Afya Timiza; Amref Health Africa **Duration**: 2016–21 **Coverage**: Samburu East and Central **Target group**: Adolescents in and of school (primary and secondary targets) **Goal**: Address teen pregnancy issues as a factor contributing to teen mortalities	● Creation of demand for RH services through community units (CUs), capacity-building health workers to improve service delivery, promotion of youth-friendly services integration ● Addressing RH and FP knowledge and unmet needs of adolescents' family planning care to prevent pregnancies	● Collaborated with partners to address barriers to access RH services, i.e., culture (anti-beading, FGM) and knowledge availability, addressed myths and misconceptions ● Involved adolescents and youth in designing of interventions (through formative assessments), peer education, and mobilization of other youth to seek services
2	**Name**: Y–ACT (Youth in Action) **Organization**: AMREF **Duration**: 2017–21 **Coverage**: Samburu County **Target group**: Adolescents and youth **Goal**: Increase the capacity of youth-led organizations to address policy and resource allocation in the county	● Advocated for policy and addressed gaps in policy ● Customization of the Adolescent and Youth-Friendly Services guidelines (in draft form) ● Initiation of the adolescent and youth nutrition strategy, gender and child-beading policies ● Meaningful youth engagements ● Capacity-building of youth-led organization ● Initiated Adolescent and Youth Technical Working Group	● Collaboration with government Department of Gender and Youth, and other partners to push for development and implementation of youth-friendly policies, e.g., gender and child-beading policies ● Utilization of youth-led organization, which promotes ownership

3	**Name**: DECIP **Organization**: AMREF **Duration:** 2019–ongoing **Coverage**: Samburu central and east **Target Group**: Adolescents and youth under 23 years of age **Goal**: Improve adolescent health and reduce cases of early pregnancies	● Mobilizing and engaging youth on RH issues ● Capacity-building and sensitizing on RH services ● Supporting FP among adolescents and women of reproductive age ● Distribution of condoms ● CHV use the Manyatta model to conduct house-to-house visits, targeting adolescents and women of reproductive age with appropriate messages on RH to demystify myths and misinformation ● Decision-makers (head of the family) are targeted and educated on RH issues and about family planning	● Improved availability of FP commodities and RH knowledge ● Addresses RH and FP knowledge and unmet needs of adolescent family planning services ● Has potential to include mentorship
4	**Name**: Wasichana Wetu Wafaulu **Organization**: AMURT **Duration:** 2017–2023 **Coverage**: Samburu East **Target Group**: Girls **Goal**: To ensure girls succeed by supporting girl-child education and empowerment	● Advocates for safe school environment for girls; household and community support for girl-child education; mentorship and outreach programs	● Incorporates county government sectors of health and education in mentorship programs ● Adolescents are involved in making decisions, and in monitoring activities

5	**Name**: Maisha Bila Steam Initiative **Organization**: Department of Gender and Social Services and Amref Health Africa **Duration**: Annual **Coverage**: Samburu East **Target**: Adolescents and youth under 23 years of age **Goal**: Nurture talent and fight drug and substance abuse through sports, and provide platforms for partners to address RH	● Promotes and supports sports (athletics) among youth and adolescents ● RH sensitization and discouraging youth and adolescents from drug abuse, early pregnancies, and early marriages	● Provides a window for integration of interventions and collaboration

4.6 Challenges in Implementing Adolescent Reproductive Health Initiatives

Implementation of ARH initiatives faces several challenges, categorized under health system, community-related, and intervention-based challenges.

Table 10 shows the challenges alongside actions recommended by key informants to address these challenges. Limited resources and poor infrastructure were major health system challenges in both counties. Issues of culture were cited as key community-related challenges.

Table 10: Challenges and Recommended Actions in Implementing Reproductive Health Initiatives in Turkana and Samburu Counties

Challenges	Recommendations to Address Challenges
Health System Challenges	
1. Limited resources and infrastructure for government interventions: ● Limited financial resources, resulting in lack of motivation and facilitation ● Limited capacity of human resources in terms of numbers, knowledge, and skills to offer appropriate adolescent RH services ● Lack of adolescent-friendly space for privacy and confidentiality ● Services availability (not provided, shortages, stockouts) ● Poor access to services (distance to facility, poor roads) 2. Misplaced priorities 3. Domestication of policies and regulation	● Establish sustainable funding mechanisms ● Enhance financial allocation policy at the county level ● Coordinate allocation of all available resources ● Strengthen existing systems and infrastructure ● Train more HCWs ● Incentivize CHVs to fill in personnel gaps ● Enhance integrated outreaches ● Assist youthful service providers and CHVs in capacity-building ● Offer services at community unit level
Community-Related Challenges	
Culture ● Resistance to new ideas and to RH awareness creation initiatives ● Length of time and challenges associated with getting community members to change	● Engage with community stakeholders including parents, elders, and chiefs, during planning of initiatives for buy-in and ownership, ● Use local media to create awareness ● Enhance integrated outreaches to CUs

mindsets, especially around the cultural norms and practices ● Suspicion and mistrust of intervention intentions ● Cultural settlement of legal matters, such as rape and defilement ● Nomadic lifestyle	● Strengthen the capacity of community health workers ● Find local champions for RH, support them and build up their resources/capacity?
Intervention-Based Challenges	
● Adolescent participation in targeted interventions ● Lack of youth-friendly centers ● Community demands ● Effects of shocks and stress (e.g., COVID-19) on interventions ● Lack of stakeholder collaboration ● Delays in getting justice in legal matters, e.g., SGBV cases ● Issues of inaccessibility and coverage of health services ● Cash transfer misappropriation	● Establish novel and holistic interventions, e.g., strengthening and utilizing the community health system/strategy ● Understand the underlying issues and adopt multipronged and need-based coordinated approaches ● Implement an innovative way of ensuring cash transfers are utilized as intended ● Establish strategic collaboration and coordination between relevant government sectors and implementing partners (stakeholders)

4.7 Capacity of the CHS to Address Issues Around ARH

According to an implementing partner in Turkana County: *"The community health strategy in the county is very well structured and well-coordinated to support the provision of adolescent sexual reproductive health. The gap is bringing CHVs on board and supporting them. Their stipends are not paid on time, and it affects their service delivery and their engagement."* The CHS utilizes CHVs at the community level to offer services at household level. There is a need to invest in CHVs by providing consistent stipends and appropriate capacity-building to effectively provide adolescent responsive services. Thus, while the CHS is well structured, its capacity to address ARH is limited by:

a) Lack of investment in adequately remunerating and capacity-building personnel.
b) Uncoordinated collaboration and partnership in the implementation of the CHS at community level.

c) Missing RH age-segregated data in the CHS monitoring system, such as adolescents presenting with pregnancy (10–14, 15–19 years of age), or adolescents receiving FP services (10–14,15–19 years of age).

4.8 Barriers to the CHS Addressing Issues Around ARH

Reported barriers to the CHS to address issues around ARH included:

1. Service provision and access barriers
   a) Limited investment in the CHAs and CHVs
   b) Fragmentation of service delivery, as opposed to integration
   c) Sparsely distributed CU link facilities
   d) Lack of professionalism in services dispensation (confidentiality and privacy)
   e) Lack of strategic partnerships
   f) Inadequate knowledge and skill among CHVs on adolescent responsive services

2. Community-based challenges
   a) Cultural practices—community preference of local herbs and traditional birth attendants
   b) Language barriers—health personnel conducting community outreach may not speak the local language.
   c) Lack of community knowledge and awareness about services offered through the CHS

4.9 Stakeholder Recommendations

4.9.1 Priority Needs

The stakeholders recommended some priority actions that would contribute significantly to the reduction of the incidence of adolescent pregnancies and would address cultural practices that predispose young girls to early marriage in both Turkana and Samburu counties:

a) Enhance stakeholder collaboration and coordination to harmonize implementation of strategies, and monitoring progress.
b) Improve service delivery via collaboration between government and stakeholders to invest in youth responsive centers, services, and focal points at health facilities and in the community.
c) Engage parents, caregivers, and community leaders in awareness of ARH issues.
d) Enhance capacity of service providers at both community and facility levels to effectively deliver ARH services
e) Improve access to ARH services by bringing them nearer to the community, ensuring sustainable availability and conducive service provision environment.
f) Integrate interventions with strategies that address poverty.
g) Enhance community and parental sensitization and engagement to address harmful cultural practices (e.g., FGM, early forced marriage) and create awareness of relevant laws at the community level.

h) Address harmful cultural norms and practices by putting in place mechanisms to enforce child protection laws and punish those who break them.

4.9.2 Needed Strategic Areas of Policy to Practice

It was noted that while relevant national policies were in place, they were yet to be fully domesticated at the county level. The following policy recommendations were made:

a) Fully domesticate relevant policies through action plans
b) Institutionalize ARH education, included in learning institutions' curriculums
c) Enforce children's rights
d) Institute collaboration mechanism among the departments of education, health, pastoralism, fisheries, agriculture, trade, youth and gender affairs, social services, internal security, and the county assembly to address adolescent pregnancies

5 Conclusions

Both Turkana and Samburu counties have numerous stakeholders implementing interventions intended to support adolescents to forge, maintain, and replicate healthy interpersonal relationships within and outside the household. These healthy relationships are supposed to afford adolescents with the life skills, guidance, social capital, protection, and encouragement they require for positive and productive transitions into parenthood, the workforce, and civil society. Some of the interventions attempt to address existing social and gender norms that affect adolescent RH outcomes (e.g., culture) and unlock opportunities for adolescents to safely realize their productive potential and aspirations. However, most of the interventions tend to address only partial aspects of ARH. Furthermore, neither the efforts nor monitoring of their impact are well coordinated. Although formal institutions, such as the CHS, and various pertinent government departments are in place, they have limited personnel capacity and lack collaborative approaches. In addition, national policies have not been fully domesticated.

Key factors contributing to pregnancy among adolescent girls in Samburu and Turkana counties include household/family, peer, health system, community (e.g., harmful cultural norms including FGM, *Moranism*, and forced early marriage), and individual- and social policy-related issues. Shocks and stresses tend to have a negative impact on adolescent sexual behavior and increase the risks of unintended pregnancies. Utilization of RH services is hampered by lack of knowledge, inaccessibility, stigma, and lack of adolescent-friendly RH services. While the CHS is well structured, it lacks both human resource and skill capacity to address ARH needs.

It is recommended that both counties establish a coordination mechanism with a multisectoral outlook to enhance multi-stakeholder collaboration, co-creation, monitoring, evaluation, and learning. Doing so would provide oversight over domestication of ASRH policies and development of well-coordinated action plans. This study identified a few interventions in both counties that depict near-holistic approaches to addressing ARH issues in the county. It is

recommended that these interventions be considered for adaptation and possible scaling up. Given the strong influence of some harmful cultural norms on ARH outcomes, interventions need to incorporate a robust component of community and parental engagement to improve awareness and possible progressive change of harmful cultural behavior.

6 References

1. Kenya National Bureau of Statistics, Ministry of Health, National AIDS Control Council, Kenya Medical Research Institute, National Council for Population and Development and ICF International. (2015): Kenya Demographic and Health Survey 2014. Nairobi, Kenya and Rockville, MD: KNBS and The DHS Program/ICF International.
2. Kinaro, J.W., Wangalwa, G., Karanja, S., Adika, B., Lengewa, C. and Masitsa, P. (2019) Socio-Cultural Barriers Influencing Utilization of Sexual and Reproductive Health (SRH) Information and Services among Adolescents and Youth 10 - 24 Years in Pastoral Communities in Kenya. Advances in Sexual Medicine, 9, 1-16. https://doi.org/10.4236/asm.2019.91001
3. Konrad K., Firk C., Uhlhaas P.J. (2013): Brain development during adolescence: neuroscientific insights into this developmental period. Dtsch Arztebl Int; 110(25): 425–31. DOI: 10.3238/arztebl.2013.0425
4. Samburu Women Trust (2016): The Unspoken Vice in Samburu County. Research Report.
5. Salam, Rehana A. et al. (2016) "Improving Adolescent Sexual and Reproductive Health: A Systematic Review of Potential Interventions." The Journal of adolescent health: official publication of the Society for Adolescent Medicine vol. 59,4S: S11-S28 https://doi.org/10.1016/j.jadohealth.2016.05.022
6. WHO (2016): Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015. Geneva: WHO; 2016.

Appendix 1: Characteristics of Participants of the Stakeholder Mapping Rapid Appraisal Workshops

Participant	Expertise, Qualification or Demographics
County FP/RH focal person	Knowledgeable about FP, HIV/STI, maternal health
County CHS focal person	Knowledgeable about Demand-side issues, community-level programming, prevailing social gender norms
Subcounty CHS focal person	Knowledgeable about prevalent issues in poorer counties
County AYSRH focal person	Expertise in specific AYSRH issues and programming
Children's services representative	Knowledgeable about protection issues – early and forced marriage, SGBV, intergenerational or transactional relationships with minors
Youth representative	Preferably 15–19 years old, female, with children from a rural part of the county, who can share challenges and experiences (a young mother could represent both the age and life stage experience: challenges of being a mother, what might work to prevent early childbearing in others, etc.)
Gender focal person	Understanding of the prevailing gender norms and challenges
Facility-based midwife	Preferably from a facility that has a high volume of adolescent clients and has experience offering FP/RH services to adolescent clients and/or caring for pregnant adolescents
CHV	Preferably 20–24 years old, from a rural part of the county, either male or female
Partners	Partner work should represent the following: - Working in HIV social support and with adolescent girls and young women (ideally, the Adolescents, Gender, Youth and Women (AGYW focal person or coordinator of a USAID DREAMS project in the county) - Working in mental health and psychosocial support - Working to address SGBV issues, especially the nonclinical aspects (prevention, legal/reporting, protection, mental health, and psychosocial support) - Working on improving wellbeing of adolescents (livelihoods, safe spaces, skills-building, etc.)

Appendix 2: Participants of the Stakeholder Mapping Rapid Appraisal Workshops

1. Turkana County

No.	Name	Gender	Affiliation	Designation/Position
1	Geoffrey Wafula	Male	USAID Nawiri	Field Research Coordinator
2	Steve Sitati	Male	USAID Nawiri	Social Behavior Change Adviser
3	Charles Lore	Male	LCRH, MOH	Nursing Officer
4	Seline Locham	Female	USAID Nawiri	Gender
5	Samuel Kablit	Male	USAID Nawiri	PSEPRI
6	Emmanuel Essau	Male	USAID Nawiri	Livestock and Agriculture Officer
7	Fridah Ewoton	Female	USAID Nawiri	Livelihood Officer
8	Edwin Chemiron	Male	USAID Nawiri	M&E
9	Samson Logiel	Male	USAID Nawiri	REAP Officer
10	Ezekiel K. Kapolon	Male	USAID Nawiri	REAP Officer
11	Shadrack Elim Lotong'a	Male	LCRH, MOH	Gender I/C LCRH
12	Teresia Macharia	Female	USAID Nawiri	R&D Specialist
13	Gabriel Ekuwam	Male	USAID Nawiri	Field Director
14	Julius Yator	Male	GOK	Director, Children's Services
15	Job Chepyegon	Male	MOH, TCG	SC CSFP
16	Peter Ing'olan	Male	USAID Nawiri	GEM
17	Salome Esinyen	Female	USAID Nawiri	Admin
18	Roy Bett	Male	MOH	Project Officer
19	Hildah Ebei	Female	MOH	GBV WPE OFFICER
20	Ibrahim Yusuf	Male	Echuman Rehab Centre	Managing Director
21	Jackson Ereboi	Male	SCC	SCC
22	Janet Ekaale	Female	USAID Nawiri	REAP Mentor
23	Alice M. Mwangi	Female	USAID Nawiri Consultant	Consultant

2. Samburu County

SN	NAME	GENDER	ORGANIZATION	Designation/Position
1	Monica Ng'ang'a	F	USAID Nawiri	QRC
2	Alice N. Mwangi	F	Consultant	Consultant
3	Simon Lemooge	M	MOH	CCO
4	Delphina Kaaman	F	MOH	CNC
5	Katra Lelesiit	F	MOH	CRHC
6	Josephine Lengopito	F	World Vision	Gender and Child Officer
7	Lemanyishoe Samuel	M	AMREF	County Coordinator
8	Samson Leerte	M	MOH	SCRHCO
9	Joseph Rotich	M	MOH	SCCHC
10	Lekatap John	M	USAID Nawiri	Attaché
11	Evans Onyiego	M	USAID Nawiri	FD
12	Samwella Lerno	F	KDEF (AY)	AYR–Nawiri
13	Lerantilei Gabriel	M	CBCC	PO
14	Salanta Salonei	F	SCG	Gender Officer
15	Simon Eris	M	USAID Nawiri	Research Coordinator
16	Augustine Lkeitan	M	MOH	CCHSC
17	Christopher Lengusuranga	M	MOH	CNO
18	Peter Lenchodor	M	Youths and Sports	DD Sports
19	Josephine Lenaiyara	F	MOH	KRCHN
20	Andrew Ngitira	M	USAID Nawiri	H&N Officer
21	Halima Kidenye	F	USAID Nawiri	H&N Officer

Appendix 3: Lists of Stakeholders Recommended for In-Depth Key Informant Interviews at the Rapid Appraisal Workshops

1. Turkana County

S/NO	TARGET SECTOR/ INTERVENTION/PARTNER	REASON FOR INCLUSION	GEOGRAPHICAL REGIONS
1	MOH	Treatment and Reproductive Health	Lodwar
2	LCRH Turkana	Treatment and Reproductive Health	LCRH Lodwar
3	MOH: Department of Preventive and Promotive Health	RH	Lodwar
4	Subcounty DPHN–Loima	Reproductive Health	Loima
5	Subcounty DPHN–North	Reproductive Health	North
6	Subcounty DPHN–South	Reproductive Health	South
7	Subcounty DPHN–East	Reproductive Health	East
8	Subcounty DPHN–West	Reproductive Health	West
9	Subcounty DPHN–Kibish	Reproductive Health	Kibish
10	Subcounty DPHN–Central	Reproductive Health	Central
11	Ministry of Labour: Inua Jamii Program		Lodwar
12	Department of Disaster Management		Lodwar
13	NDMA–HSNP		Lodwar
14	CDF	Education	Lodwar
15	Department of Children's Services	Education, Child rights, Child Protection	Lodwar
16	MTGYA	GBV /Legal Redress	Lodwar
17	Police	GBV /Legal Redress	Lodwar
18	Turkana Youth Council		Lodwar -Turkana County
19	Lodwar Wellness Centre/IRC	SGBV and referrals	Lodwar -LCRH
20	Lodwar Medical–Diocese of Lodwar	Reproductive Health, treatment,	Lodwar
21	CARITAS LODWAR (Diocese of LODWAR)	Education, child protection, health care support, capacity-building of families, support children with special needs homes	Lodwar
22	AIC Ministries (Health Centers) Lodwar, Kalokol, Lokichoggio	Reproductive health, treatment	Kalokol
23	RCEA		South
24	TCGDN–Network		Turkana Central
25	Sapcone-Protection	GBV/legal redress	Lodwar

26	Mission of Hope		
27	Concern Worldwide		Lodwar
28	AMPATH		Lodwar
29	Livestock Market Systems Activity (LMS)		Lodwar
30	Kenya Red Cross	GBV/legal redress	Lodwar
31	Youth Fund	Gender mainstreaming and empowerment	Lodwar
32	Mercy Corps	Gender mainstreaming and empowerment	Lodwar
33	Terre Des Hommes	Child protection	Lodwar
35	UNHCR		Kakuma–West
36	LOKADO	Women in peace and conflict resolution	Kakuma–West
37	UN Women	Women in leadership	Lodwar
38	Aupwal Community Development Organization	Peace, livelihoods, and natural resources	Kaikor–North
39	Akide Elites Initiative (AKIDEIN)	Research, livelihoods, empowerment, and environment, peace	Kapedo–East
40	Kerio Kalapata Development Organization (KEKADO)	Livelihoods	Kerio–Turkana Central
41	Turkana Environmental Resource Association (TERA)	Natural resources (forests), livelihoods	Kakuma–West
42	Asegis Community Network	Water, Sanitation, and Hygiene (WASH)	Lorugum–Loima
43	Nakukulas Empowerment Development Organization (NEDO)	Community Empowerment	Lokichar–South
44	APESE ERE Youth Empowerment Group	HIV/AID sensitization and empowerment of adolescent in Loima County on issues of Child rights, Child protection, HIV/AIDS	Lokichar–South
45	Save the Children	Child protection, support PSSG in facilities, livelihood support in form of cash transfers	Lodwar
46	Elemi Community Development	Achengei Abdi	Lodwar
47	ACDI /OCA		Lodwar
48	World Vision Kenya	GF HIV Project focusing on AYSRH	Lodwar
49	One Chief from each subcounty		Subcounties/wards
50	One leader of an active community health unit from each subcounty	Community-level efforts	Subcounties/wards

2. Samburu County

S/NO	TARGET SECTOR/ INTERVENTION/ PARTNER	TARGET RESPONDENT	REASON FOR INCLUSION	GEOGRAPHICAL REGIONS (WARDS AND SUBCOUNTY)
1	County government	CECs: Health	RH policy	Samburu County–Maralal
2	County government	CECs: Gender Culture Sports and Social Services	Gender policy	Samburu County - Maralal
3	Ministry of Education	Director–Vocational Training	Institutional policy	Samburu County–Maralal
4	Special programs	CEO–Coordinator	Maternal health and nutrition	Samburu County–Maralal
5	MOH, Department of Health	County Director	RH, maternal health, and nutrition	Samburu County–Maralal
6		SRHR Coordinator		
7	MOH, Adolescent, and Reproductive Health department	County Clinical Officer–Adolescent and Youth program coordinator	RH, maternal health, and nutrition	Samburu County–Maralal
8	Youth, Children, Social Services, and Child Protection	Children's Office - National Government	Child protection	Samburu County–Maralal
9	Department of Gender	Director–Gender	Gender issues	Samburu County–Maralal
10	Department of Agriculture, Veterinary Services, and Fisheries	AG-CO/Director - Agriculture	Livelihoods	Samburu County–Maralal
11	Persons with disabilities	Representative	Youth representative	Samburu County–Maralal
12	Population Reference Bureau		RH	Samburu County–Maralal
13	Youth Fund–Trade	Director	Economic empowerment	Samburu County–Maralal
14	NDMA	Coordinator	Resilience	Samburu County–Maralal
15	Director of Administration	Director	Security	Samburu County–Maralal

16	National security	Police Gender Desk Person/OCS	Legal redress	Samburu County–Maralal
17	Anti-FGM Board	CEO		Samburu County–Maralal
18	AMREF (Y-ACT Project)	Project Officer	Gender, Health, and Youth Advocacy	Samburu Central and East
19	AMREF (DESIP)	Project in charge		Samburu North
20	AFYA TIMIZA	In charge		Samburu County
21	KCB Maralal	Manager	COVID response activities, sanitary towels for adolescent girls	Samburu County
22	World Vision–Kenya	In charge	Child protection	Samburu Central
23	BOMA	In charge	ARH programming	Samburu Central
24	Feed the Children	Manager	ARH programming	Samburu East
25	Child Fund	In charge	ARH programming	Samburu Central
26	ACTED	In charge	ARH programming	Samburu Central
27	NEST		ARH programming	Samburu Central
28	Mercy Corps	Field Director	ARH programming	Samburu Central
29	The Kenya Red Cross		ARH programming	Samburu Central
30	UNICEF		ARH programming	Samburu Central
31	World Food Program		ARH programming	Samburu Central
32	CBCC Africa		ARH programming	Samburu Central
33	Food and agriculture organization		ARH programming	Samburu Central
34	NARIG		ARH programming	Samburu Central
35	NRT	Director	ARH programming	Samburu East
36	AMURT Programs	Program Manager	ARH programming	Samburu East
37	Samburu Girls Foundation		ARH programming	Samburu Central - Maralal
38	AMREF-Be-for-We		ARH programming	Samburu East
39	KAG–Compassion		ARH programming	Samburu Central
40	Naretoi Development Initiatives (CBO)	Project Officer	Basic health awareness and maternal-child nutrition, youth socioeconomic empowerment, AYSRHR, peace-building, conflict impact mitigation, and counseling; livelihood activities such as	Samburu East and North–Barsaloi - Opiroi, Suyian - Maralal

			agribusiness and entrepreneurship	
41	Empower Pastoralist Organization of Kenya (EPOK)	Founder	Livelihood, SRHR, advocating on public participation	Samburu Central Suguta ward
42	Samburu Bright Future	In charge	Livelihood, mentorship, youth leadership, empowerment	Samburu Central
43	Ngutuk Elenat Health Unit	CHA	SRHR, GBV, maternal health and nutrition	Samburu East– Waso ward
44	Londunyo Kwel	CHA	RHR, nutrition, GBV issues	Samburu East– Wamba ward
45	Swari Community Group	CHA in charge	Mentorship program, RHR, maternal health	Samburu East– Waso ward
46	Pastoralist Integrated Development Initiative		Health and sanitation	Central, North, and East
47	Nkopiro Foundation	In charge	Advocacy, SRHR, talent naturing and leadership, health and nutrition	Samburu Central– Lodokejeck ward
48	Samburu Women Empowering Integrated Program (SWEIP)	Chairperson	Women's empowerment, GBV/human rights, food and nutrition	Samburu Central
49	Light of the Society Youth Group	Founder	Youth Mentorship	Samburu North- Opiroi Baawa ward
50-55	Subcounty/ward strategic persons	6 CHAs		Central, North, and East
56-58		3 subcounty Gender Officers		Central, North, and East
59-61		3 CHS Focal Persons		Central, North, and East
62-64		3 subcounty RH coordinators		Central, North, and East
65-70		6 Chiefs		Central, North, and East
71-73		3 subcounty Gender Desk Officers (police)		Central, North, and East
74-76		3 subcounty admins		Central, North, and East
77-82		6 Elders		Central, North, and East

CONTACT

DARIUS RADCLIFFE

Chief of Party (CoP), USAID Nawiri
MERCY CORPS
tel +254 701 442 396 | skype mdariusradcliffe
The Almont Park
Church Rd. | Westlands – Nairobi, Kenya

This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents of this report are the responsibility of Mercy Corps and do not necessarily reflect the views of USAID or the United States Government.

Nawiri is a consortium of:

African Population and Health Research Center