TOP CONFIDENTIAL

Perceptions of GBV & SRHR of Right Holders, Male Engagement, Health Facilities & Local Structures: The Accelerate project

Qualitative Research Findings

Report written by Lead Consultant, Masila Syengo**, BSc, MA**
Reviewed by Dr. Jerry Okal, **PhD**
Senior Social Researcher
Remeal Africa Consulting Ltd
www.remeal.co.ke

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Abbreviations

AYA	Adolescent and Young Adults
CBO	Community Based Organization
CHVs	Community Health Volunteers
CIP	Costed Implementation Plan
DHIS	District Health Information System
EC	Emergency Contraceptive
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GBV	Gender-Based Violence
GVRC	Gender-Based Violence Recovery Centre
HCD	Human Centre Design
HIV	Human Immunodeficiency Virus
HNQIS	Health Network Quality Improvement System
HTPS	Harmful Traditional Practices
IDI	In-Depth Interview
IEC	Information Education and Communication
IPV	Intimate Partner Violence
KDHS	Kenya Demographic Health Survey
KHIS	Kenya Health Information System
KII	Key Informant Interview
KQMIS	Kenya Quality Management Information System
MCH	Maternal Child Health
MCPR	Modern Contraceptive Prevalence Rate
MEAL	Monitoring Evaluation Accountability and Learning
MII+	Method Information Index Plus
MOH	Ministry of Health
OPD	Out-Patient Department
PEP	Post-Exposure Prophylaxis
PRC	Post Rape Care
PS Kenya	Population Services Kenya
PSI	Population Services International
SBCC	Social and Behavior Change Communication
SGBV	Sexual Gender-Based Violence
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
TOC	Theory of Change
WRA	Women of Reproductive Age

Executive Summary

Kenya has made great strides toward increased uptake of family planning, including recently surpassing its FP2020 target of 58% modern contraceptive use by married women (FP2020) many women still have unmet need for contraception and disaggregated data by region show wide disparity with very low use in some of the regions/counties. Existing literature shows multiple barriers hinder the uptake of family planning services such as low awareness of FP methods (e.g., 50% among WRA in Mandera), religious and sociocultural factors including misconception and myths, and lack of spousal support. Furthermore, health system factors including continuous availability of contraceptive commodities including the availability of a trained provider/equipment; sufficient counseling bias and other negative behaviors, previous experiences at the service delivery point (SDP) including privacy, confidentiality and respect, out-of-pocket cost, distance to the SDP, among other reasons. Similarly, multiple community-level factors preclude access to timely, quality, and affordable support and care services among many survivors of GBV including sexual violence. Some of the key impediments include lack of awareness of existing structures in the community and/or lack of functional support and care structures fear of retaliation and abandonment given that in seeking for support services may end up revealing the perpetrator. In light of the above, PSK conducted formative qualitative research to better understand the learning agenda of right holders and male engagement interventions pathways to enhance knowledge and adaptation of contraceptive uptake and GBV access through a comprehensive qualitative multi-pronged approach.

METHODOLOGY

The study was formative qualitative research that entailed focus group discussions with male engagement participant drawn from young-unmarried men (boys), older-married men, young-unmarried women (girls) and older-married women and FGDs with right holders who had similar characteristics. Data collection was carried out in West Pokot, Garissa, Narok and Kwale Counties which acted as Accelerate program's "learning labs". These counties were selected due to the existing accelerate interventions that focuses on exploring a male engagement learning question to gather localized insights on strategies which can be adopted and scaled up to involve men as agents for advocating for improved SRH practices and increased respect for women's rights. Both counties have a larger cohort population, including young girls and women, boys and men in their 18-24 and 25-49 age brackets; an urban-peri-urban population that is spread to allow for broadly applicable lessons learned; existing relationships with NGOs; and a network of SRHR and GBV providers. Key informant interviews (KIIs), Focus group discussions (FGDs) were conducted with male engagement participants, right holders and local structures that included CHVs/CBO staff, and local community leaders including social-cultural leaders, community elders, health providers and leaders of various male and female groups such as youth and Boda-Boda, among others.

RESULTS

Findings from the Right Holders: focus group discussions

Knowledge of contraceptive methods is fairly high in the four counties of Narok, Garissa, Kwale and West Pokot. The commonly mentioned methods included: pills, Injectable-Depo, implants-Norplant and condoms. Similarly, non-conventional birth control methods were mentioned and were used. These include traditional herbs, extended breastfeeding, semen withdrawal, and the use of a calendar methods.

Contraceptives use was common among areas where Christianity was dominant than areas such as Garissa where Islam is dominant. Depo-Injections and Norplant-implants were commonly used in non-Muslim areas while extended breastfeeding was predominantly used in the Muslim dominated areas.

Motivation for Contraceptive Uptake was hinged on the prevailing economic conditions that drive users to have fewer children to enable them have improved quality of life.

Least preferred methods were almost similar in the Counties, but religion was the key determining factor. In Garissa, condoms was the least preferred method due to religious and cultural norms. Although older women in Narok and Kwale preferred IUDs and Coils, it was not universally accepted.

Contraceptive use by young girls was generally not encouraged in all the four counties. Use of contraceptives was allowed by family members under unique circumstances such as when the young member of the family got pregnant and had a child.

Women and girls who were married or in stable relationship often needed consent and approval from their partners to use contraceptives. However, lack of partner support or consent led to discreet use of contraceptives.

Contraceptive side effects commonly mentioned included. prolonged bleeding, obesity, joint pains, low libido, high blood pressure, dizziness during sexual activity and interference of menstrual cycle.

Contraceptive access challenges. Commonly mentioned challenges included limited choices of contraceptives available, distance to the facilities, social and cultural beliefs, provider attitudes, long wait time and associated loss of time at facilities.

Discontinuation of FP use was primarily linked with fear of side effects. Other reasons for discontinuation were long queues at the health facilities, stock-outs, negative perceptions, wait time to receive certain methods such as Norplant which required specialized clinicians and cost of service.

Changes observed in the use of Family Planning methods. Evidence from Narok, Kwale and West Pokot indicate an increase in women accessing family planning services which is associated with the social behavioral interventions such as SBCC that promotes FP use.

Male Engagement Contraceptives Discourse demonstrates that married men opt for long-term contraceptives, while the younger men prefer short-term contraceptive methods.
Abortion is used a form of contraceptive. Some young people resorted abortion as a way of preventing unintended or unwanted pregnancies.

Knowledge of GBV is generally high and perpetrators are known. GBV was said to be common in the community and often perpetrated by known family members, community members and sexual partners. The most common forms of GBV included intimate partner violence (IPV), early marriages, female genital mutilation, and rape. Some participants affirmed to have witnessed these types of violence happening in the community.

Perspectives on GBV

Older Women and young were commonly subjected to GBV. Women were targeted by men for violence while young girls were mainly targeted by their mothers with early marriage and FGM.

Common types of Violence included sexual violence, marital rape, FGM and physical violence. Women experienced violence of disrespect to their partners, leaving home without their partner's permission or refusal to have their children punished. Young girls were married off so that their families could support themselves from the dowry while FGM was a rite of passage to adulthood.

Violence Disclosure Pathways occurred within and outside the realm of families. Disclosure was made to family members such as mothers, sisters, and others like best friends and religious leaders.

Access to GBV services mainly occurred at health facilities although this was mired by stock out of commodities. Services provided entail counseling, medical and sample collection for legal evidence. Perennial shortage of essential medicines and medical equipment hindered provision of comprehensive services.

Access to justice entails local community structures, the police, and the judiciary. Typically cases of GBV go through the village chairman or the local chief, law enforcement officers, and potentially the justice system.

Barriers to GBV services were varied and included individual level and structural barriers. Some of the barriers to GBV services included corruption, fear, lack of transport to the GBVRC Centre's and finances to obtain legal representation.

Findings from male Engagement Interviews: Key Informant Interviews

Contraceptive use in Narok and Kwale was attributed to difficult economic conditions which necessitate smaller families. However, resistance to contraceptive use was rife due to concerns around infertility, lack of pleasure during sex, promiscuity, cultural and religious grounds and changes in the physiological makeup of the women.

Contraceptive Use was limited in Garissa County and only accepted in rare circumstances involving rape. In other counties such as Kwale, West Pokot and Narok the benefits were mainly perceived from an economic angle.

Opportunities to Engage Men and Boys in Family Planning occur when women ask for permission to use family planning methods. Overall, men are included in family planning discussions heads of the household.

GBV appears to be more prevalent in in Narok, Kwale, and Garissa where women and girls are more likely to encounter gender-based violence. The types of violence documented includes forced marriage, FGM, and early marriage.

The main drivers of violence meted at women and girls included poverty, alcoholism, denial of conjugal rights, economic gain and drug and substance abuse. On the other hand, aggressive behavior was noted among women and mainly attributed to psychological abuse, painful sex due to FGM and poverty.

GBV is addressed at the community level. Community members, CHVs, teachers, religious and community leaders, and organized forums raise awareness on the effects of GBV.

Changes in SRH and GBV Response observed over the last 12 months in West Pokot. Data from the health facilities indicate an increase in the number of women and men seeking family planning services.

Changes observed among Duty Bearers (Community Leaders). Engagements with community leaders, the police and the children protection department are happening, and they are getting involved in SRHR and GBV consultations.

Changes in the health facility and referral pathways has improved in the last 12 months. Community members have access to contraceptives unlike previously when they had to visit the health facilities.

Changes observed in Duty Bearers (Community Leaders) responsiveness to SRHR and GBV. The local administration and religious leaders such as chiefs and sheikhs have become more involved with SRHR and GBV at the community level.

Changes in the health facility and referral pathways observed over the last 12 months in Narok county. Access to SRH and GBV services has improved through enhanced referrals, linkages and establishment of hotline numbers.

Findings from Health Providers: in-depth interviews

Comprehensive services for SRHR and GBV is needed for quality service delivery.
Integrated services is need at health facilities and referrals made to higher-level facilities.
Family planning services offered at facilities include both long-term and short-term contraceptive methods. Older women prefer long term contraceptive methods while the adolescents and young people prefer short term family planning methods.

Post-abortion services are provided in most health facilities. In most cases, post-abortion clients are referrals from lower-level facilities

Women use family planning methods without the approval of their partners. Although this is viewed as disrespectful and against community values. The community also views use of contraceptives among adolescents as encouraging sexual activity. Similarly, for married women, the use of contraceptives is considered a sign of prostitution.

Reasons for low contraceptive uptake is varied. These include myths and misconceptions, side effects, low levels of education, negative perceptions on the use of contraceptives, the lack of awareness and limited information on FP, adolescents' inability to consent and lack of youth-friendly services/infrastructure at the facilities.

Physical and sexual violence are the most common types of violence in Kwale County. Sexual violence is most rampant among adolescents and young girls who are either raped or forced into engaging into nonconsensual sexual activity. Physical violence is most common among married partners; either intimate partner violence by the men or women.

Integration of GBV services in routine SRH is feasible and occurring. Integration of GBV services into routine SRH is feasible and is an ongoing practice in some facilities. While the facilities are open to embracing integration, there are underlying challenges that hinder integration of services. These include inadequate staffing, lack of appropriate infrastructure, inadequate space, and skills to handle such cases.

Recommendations

- Support community-based organizations and women's groups through SBCC channels that create local community grassroots chapters to educate women of reproductive age on the need and importance of using contraceptives across all four counties. Findings from right holders elucidate worrying trends of naïve women not knowing the importance of using long-term contraceptives and their benefits. The focus should be mounted on LTFP Implants and copper IUDs coils.
- Address the perennial stock-outs of long-term contraceptives preferred by women in rural counties. Also, address suspicion and negative myths about coils by educating women and men on their importance including providing trained health providers who are knowledgeable in the service provision of coils.
- Enhance youth-led intervention that promotes YFS-SRHR services among the youthful generation at the sub-county health facilities through innovative SBCC strategies that involve both girls and boys at the community level in Garissa and West Pokot counties where social-cultural norms were prevalent.
- *Support and work with social media peer education programs implementing SRHR programs*
  As observed from the findings, largely access to online digital contraceptives services where done by peers and friends through several online pathways, it will be important to develop or work with existing community networks of peer-led interventions and recruit social media peer educators to support demand creation for online digital youth-friendly products, while conducting SRHR educational sessions through the online peer community.
- Strengthen SRHR services at the point of care to ensure that survivors of SGBV optimize comprehensive care and treatment services: Findings from the key informants CHVs show that at the sub-county health facility lack of essential medicines such as analgesics and antibiotics essential for the care and treatment of survivors of SGBV is a critical component that needs to be addressed. Taking note that only comprehensive services were available at the county health facilities which required additional resources to access these needed services for survivors of SGBV
- Continued sustained SGBV interventions in Rural Kwale, Narok, West Pokot and Garissa Counties while optimizing male engagement strategies through SBCC: Findings from right holders and male engagement shows that primary participants were of the opinion that male engagement interventions targeting Men young and older in having candid conversations on contraceptives pathways and SGBV discussion would greatly enable positive behavior change and enhance awareness of FP choice when men become champions of Family planning ambassadors.
- Support and enhance trauma counseling training for service providers at the sub-county health facilities who will provide the necessary psychosocial support for survivors of SGBV
- Support sub-county facilities with the provision of an evidence collection package that allows specimen collection and storage to support legal representation.
- Support and enhance a paralegal community-based network of Women that empowers Women and girls to have the confidence and report cases of sexual and gender-based violence.

Background and Rationale

Evidence shows millions of Kenyan girls are particularly vulnerable to early teenage pregnancy and motherhood, often associated with risky sexual behaviours and early child marriages. According to recent national estimates, approximately a third or 37% of Kenyan girls are married off at the exact age of 18 years or below, including 8% who are married by the exact age of 15 (KNBS 2014) Furthermore, the body of knowledge suggests wide variations exist in the performance of SRH indicators, given some counties perform unfavourably in comparison to the national estimates. For instance, in 2014, among women aged 20-49, the national median age at first sexual intercourse was 18 years, compared with less than 16 in Homabay and Samburu, less than 17 in Kwale and Narok, and was less than 18 in West Pokot, Marsabit, Elgeyo Marakwet and Baringo. While the national estimate for teenage pregnancy/motherhood was 18%, this was as high as 40% in Narok, 33% in Homabay; 20-26% in Kajiado, West Pokot, Kilifi and Kwale.

Kenya has made great strides toward increased uptake of family planning, including recently surpassing its FP2020 target of 58% modern contraceptive use by married women (FP2020) many women still have unmet need for contraception and disaggregated data by region show wide disparity with very low use in some of the regions/counties. Specifically, by 2014, almost a fifth (18%) of currently married women expressed unmet need for family planning services, including 9% in need of spacing and 8% in need of limiting (KNBS 2014) Some counties reported very low use of modern contraception among married women, which was nearly five times less than the national estimate, including 2-6% in Mandera and Garissa, 11-13% in Marsabit and West Pokot, was also low in Samburu (20%), Baringo, Kilifi, Kwale and Narok (33-38%), and ranged between 44% in Elgeyo Marakwet and 54% in Nairobi (KNBS,2014). Furthermore, while the nnational estimate shows nearly universal awareness of any method of family planning among married WRA (99%), only half of married women (50%) in Mandera were knowledgeable, 76% in West Pokot, and 87% in Garissa (KNBS 2014).

Documented literature shows, multiple barriers hinder the uptake of family planning services such as low awareness of FP methods (e.g., 50% among WRA in Mandera), religious and sociocultural factors including misconception and myths, and lack of spousal support. Furthermore, a woman's decision to adopt a method to continue using a method or even to switch methods is influenced by multiple health system factors including continuous availability of contraceptive commodities including the availability of a trained provider/equipment; sufficient counseling bias and other negative behaviors, previous experiences at the service delivery point (SDP) including privacy, confidentiality and respect, out-of-pocket cost, distance to the SDP, among other reasons (PMA 2020a, 2020b, PS Kenya 2020).

Similarly, multiple community-level factors preclude access to timely, quality, and affordable support and care services among many survivors of GBV including sexual violence. Some of the key impediments include lack of awareness of existing structures in the community and/or lack of functional support and care structures (Mwangi & Jaldesa, 2009; Muuo et al, 2020, Wangamati et al 2019,) fear of retaliation and abandonment given that in seeking for support services may end up revealing the perpetrator (Muuo et al 2020). Gender based violence, such as rape, is faced

with stigmatization which discourage women/girls from seeking services, as women expressed fear that their case and information may not be kept confidential (Muuo et al 2020), and as such, in some settings, may limit girl's chance of getting married in the future (Mwangi & Jaldesa, 2009). Furthermore, deep-rooted sociocultural norms around the role of women in protecting marriage and family privacy have played a major role in limiting women's ability to utilize healthcare services. For instance, intimate partner violence (IPV) is widely regarded as a normal occurrence, thus the survivors do not see the need to seek for medical services.

In light of the above, PSK conducted a formative qualitative research to better understand the learning agenda of right holders and male engagement interventions pathways to enhance knowledge and adaptation of contraceptive uptake and GBV access through a comprehensive qualitative multi-pronged approach supported by focus group discussions with male engagement participant drawn from young-unmarried men (boys), older-married men, young-unmarried women (girls) and older-married women and FGDs with right holders who were having similar characteristics and mutually exclusive, who participated in the early phase of data collection. Data collection was carried out in West Pokot, Garissa, Narok and Kwale Counties. These counties were selected due to the existing accelerate interventions on programs that focus on exploring a male engagement learning question to gather localized insights on strategies which can be adopted and scaled up to involve men as agents for advocating for improved SRH practices and increased respect for women's rights. Both counties have a larger cohort population, including young girls and women, boys and men in their 18-24 and 25-49 age brackets; an urban-peri-urban population that is spread to allow for broadly applicable lessons learned; existing relationships with NGOs; and a network of SRHR and GBV providers.

Objective

a) To explore experiences regarding shifts in individual attitudes, perceived social norms, and practices of GBV, FGM/C and early child marriage, among the targeted population reached by Accelerate project
b) To explore changes in the ability to exercise SRHR among girls and women reached by Accelerate project
c) To assess the involvement of men and boys in the SRHR agenda and GBV/HTPs prevention and response
d) To explore effective strategies for leveraging local structures, duty bearers, and males to promote SBCC messaging around SRHR/GBV and respect for human rights
e) To explore strategies for improving the delivery of timely, quality, and integrated SRH/GBV services among health facilities supported by Accelerate

Methods

Four counties were selected to serve as the program's "learning labs". These learning labs were purposively selected to represent a diversity of settings such as urbanicity, religion and cultural practices. These counties included West Pokot County which represented a pastoralist Pokot community in the North Rift; Narok County represented a rural setting characterized by nomadic Maasai culture; Kwale County represented a rural coastal area dominated by Mijikenda culture; while Garissa County represented a North Eastern area dominated by Muslim and nomadic Somalia culture.

Study Population

Male Engagement Participants

Recognizing the positive role that men and boys can play in violence prevention, accelerate program explored a male engagement learning question to gather localized insights on strategies which could be adopted and scaled up to involve men as agents for advocating and improving sexual reproductive health practices and increased respect for women's rights.

Key informant interviews (KIIs) were conducted among purposively selected CHVs/CBO staff, and local community leaders including social-cultural leaders, community elders, and leaders of various male and female groups such as youth and Boda-Boda, among others. A semi-structured interview guide was administered among 30 respondents. This study component was to explore salient perspectives and receptiveness of male participation strategies at the family, and community level to promote, male involvement in SRH, and GBV agenda.

Focus group discussions (FGDs): were conducted with males and females residing in the selected study clusters. Focus groups were formulated by gender, marital status, and age to ensure open conversations. The participants were purposively selected by discussants aged 18 years and above who were in a sexual relationship irrespective of marital status. Specifically, four different groups were formulated including young-unmarried men (boys), older-married men, young-unmarried women (girls) and older-married women. A semi-structured FGD guide comprising of

open-ended questions was administered to explore whether the current strategies for male engagement were effective, and what program modifications and considerations were required for effective, and sustainable male engagement.

Right Holders Participants

Similarly, the rights holders' research component included advocates of sexual reproductive health, women and men in the four purposive selected study counties. Rights holders included girls, women, boys, and men, who promoted respect for human rights including shifting attitudes, behaviors, gender, and socio-cultural norms that prevented and responded to GBV.

Focus group discussions (FGDs): participants were recruited to track trajectory in knowledge, attitudes, practices, and societal norms around SRHR and GBV topics. Individuals participating in this cohort were recruited locally from a small geographical area (such as a village or an estate). This recruitment strategy was likely to produce a well-constituted and homogeneous cohort given that participants are more likely to exhibit similar attributes such as exposure to program activities, including SBC messages on SRHR, GBV and human rights, and to hold similar perspectives regarding societal norms. Demographic attributes such as age and marital status were considered during recruitment to ensure open discussion.

Health Facility Participants

Health Facility Providers in-depth interviews: A semi-structured interview guide was administered among 46 purposively selected health workers across all the four counties in both sub-county and county health facilities. To capture diversified perspectives, health workers sampled were composed of health facility in-charges and front-line health workers from both private and public health sectors, different levels-of-care, and different SRH/GBV service delivery departments such as MCH/FP, OPD, Youth Friendly Centers, and Maternity department were invited to participate. Informed verbal consent were administered to all participating health care providers. The study aimed at gathering provider's experiences and perceptions relating to SRH/GBV service provision, providers access to job aids, commodities, treatments, equipment and laboratory or diagnostic tests, including exposure to SRHR training and supervision. Providers perspective on SRHR/GBV integration was explored aimed at better understanding the facility's plan and efforts to integrate services, for improving and uptake of SRH/GBV service delivery.

Local Structure Participants

Focus group discussions (FGDs): focused group discussion were conducted with Accelerate sub-contracted CBOs, and community health volunteers (CHVs) in the respective study sites, who were directly involved in Accelerate SBC implementation activities in Kwale, Narok, West Pokot and Garissa. Participants from the two groups (CBOs and CHVs) were purposively sampled to ensure representation and diversity of perspectives. Interviews were conducted separately for this two groups aimed at elucidating varying experiences. A semi-structured FGD guide, comprising of open-ended questions was administered to the CBOs and CHVs exploring local structure insights on what had worked well, what had not worked well while implementing Accelerate SBC activities, challenges faced, what strategies were required for program improvement, and localized ideas that provided program practical solutions aimed at addressing specific implementation gaps and challenges. A verbal informed consent was administered to all participants prior to their study engagement.

Data Collection Procedures

Qualitative interviews were recorded after seeking verbal permission from the participants. During consenting processes.

Data Analysis

We obtained and went through all the relevant background information related to the assignment (project documents, tools, information and participant background. We read through a sample of transcripts from each of the categories of FGDs and KIIs participants from whom data was collected in the respective four counties. We were able to develop a project code book in word version that was reviewed by two independent social scientists (PSK and PSI and the consultant) in preparation for exporting the same code book into Dedoose.

We later conducted Dedoose coding and memoing using the code book to check for coding reliability. Two independent social scientists independently coded the transcripts into and thereafter compared the individual outputs for alignment. All the codes were subjected to reliability checks, and misalignment was addressed. During this phase, analytical memos were developed and iteratively produced to distil any emerging issues. A thematic framework was adopted based on salient themes and emerging patterns from the coding activities, which was used to develop key salient themes that were related to the objectives and were deliberated upon by two social scientists and the coding teams.

The findings were written based on the key emerging themes. Data synthesis techniques such as data mapping, interpretation, charting to define concepts, and development of broad thematic themes consistent with the qualitative assessment approach was employed by assessing each objective. The findings section captures a reflection of the FGDs and KII's participant's insights during the qualitative data collection.

FGD Findings from Right Holders and Male Engagement

Knowledge of Contraception

FGD discussants, across gender and age (among the right holders and male engagement groups) in the four counties of Narok, Garissa, Kwale and West Pokot had knowledge of contraceptives (including different types of contraceptives) and how to use them. Narratives also showed understanding of child spacing. Both older and youthful participants mentioned and identified the following contraceptive methods: pills, Injectable-Depo, implants- Norplant and condoms.

> *"R7: coils, condoms and pills."* ***FGD-GSA-Mature Men-MM002***
>
> *"R5: Injection for three months and CDs".* ***FGD, NRK-Youth-300522***
>
> *"R7: There is also pills, condom and injectable".* ***FGD, KWL-Youth-03***
>
> *"R4: There is the 3 years' family planning method which is inserted in the arm. (NORPLANT)"* **FGD-WP-Mature Women-030622**

Similarly, a vast majority of women and men identified non-conventional birth control methods that were used by women of reproductive age. These include the use of traditional herbs, extended breastfeeding, semen withdrawal, and the use of a calendar methods.

> *"R8: In the past when a woman gives birth, the husband would avoid her sexually, during her period he would not have sex with her, until 2 weeks' elapse, and you can't get pregnant. There was no contraception and they still managed to space children."* ***FGD-NRK-Mature Women FM2-040622***

> *R2"Modern, you can use it for a short period or long period. But traditional herbs can make you be infertile completely. And most if you don't want kids anymore, then you can use those herbs."* ***FGD-NRK-Youth Female-YF***

> *"R7: there is natural family planning whereby the husband keeps away from the wife for at least years that is common for the community."* ***FGD, GSA-Mature Men MY 01***

> *"R6: What I know is when a woman gives birth, as a man you don't come near her room until a child grows up to two years but communication they talk to each other."* ***FGD GSA-Mature Men-MM01***

Preferred Contraceptive Methods

In Garissa County, the majority of women who professed the Christian faith preferred using the three months injectables, while most Muslim women of Somali origin used extended breastfeeding which is rooted in the Somali cultural norms and method of family planning.

> *"R5: Because for the tablet you forget to take but injection you inject one time and you cannot forget."* ***FGD GSA-Youth FY01***

> *"R3: In our Somali community is not necessary to use family planning because women won't get out she usually stays at home and has their future we commonly use the spacing of children they can do for a period of two or three years after childbirth."* ***FGD-GSA-Mature Male-MM01***

Notably, the right holders averred that, depo-Injections and Norplant-implants were the most preferred methods. This was invariably so among married couples in Narok as compared to other counties. The preference for Depo and Norplant were linked with limited experiences of side effects and availability at health facilities. Additionally, the cost of these commodities was fair compared to other methods such as tubal ligation, coils and Femi-plan which costed more and hadlimited stock. According to the participants, condoms and emergency contraceptives (P2) were preferred and commonly used by young people. Long-term methods also appeared to be preferred by young girls to allow them complete secondary school.

> *"R1: Most of the school-going children are using P2, which is a pill that one uses after having sex to protect yourself from getting pregnant, it is commonly used and it is readily available and that is the common one to them."* ***FGD-NRK-Mature Men-MM***

> *"R: At the moment you find that most girls have studied and they do not want to get kids earlier thus prefer family planning because they do not want a child at a young age or maybe they want to finish their studies."* ***FGD-NRK-Youth-300522***

> *"R5: Women who use contraception most of them hide. They prefer the implant, when they take the baby for antenatal care, for example, they get the implant, and then just come and relax."* ***FGD-NRK-Mature Women FM2-040622***

> *"R8: Male condoms are commonly used because it serves two purposes; prevent STD (sexually transmitted diseases) and also prevent pregnancy but if you only use the pills then you can get the STD (sexually transmitted diseases)" (**FGD KWL-Youth-M03)***

To understand participants' perceptions and choice of family planning methods, they were asked to comment on the least preferred methods. In Garissa, condoms were among the least preferred methods due to the religious and cultural norms among the Somali community which deterred them from using condoms. However, they were ambivalent on the use of the withdrawal method and abstinence which were rarely mentioned by both adults and young men.

> *"R8 in my opinion in the Somali community condoms are not commonly used"* ***(FGD-GSA-Mature Men 01)***

> *"R11: let me tell you why natural methods are not allowed, you can get pregnant in an unexpected way and according to the economy now you find yourself having many children and you can't get for them daily meals so that means you have to control yourself if you want to get two and you have to educate and have the best life for them then you may have to use contraceptives or get more and you end up suffering in life"* ***FGD-GSA Mature Women FM01***

Evidence from right-holder's and male engagement participants elucidates barriers and opportunities for IUDs and coils. The challenges identified by both genders on these methods revolved around the myths and misconceptions, cost and the lack of provider training to insert them. An underlying concern for both male and female participants was the potential health risk revolving insertion and removal of the method.

> *"R6: There are no medical experts to insert the coil properly in this locality."* ***FGD-WP-Mature Women-MM-30072022***

> *"R3: There are repercussions of having a coil, for example, a coil triggers cancer cells, if not detected early and found that the coil triggers cancers you are in trouble. Because cancer treatment is only available in India and you don't have the resources to go there.*

So you find that coil is not well received by the society better the other family planning methods but not coil, it's in not well perceived in this community" ***(FGD-KWL- Young-YM03)***

"R4: effects about that coil. It has side effects if you inserted a coil and maybe the man is drunkard if he pushes that coil up to the stomach you will die" ***(FGD-GSA-Mature Women 01)***

"R9 if she uses coil the one inserted in the vagina, she will lose the sweetness and his men will go out of marriage because of the loss of sweetness. Coils can affect your marriage and cause the woman also to go out of marriage." ***(FGD-GSA-Mature Women M01)***

Comparably, narratives from Garissa County suggest negative views on IUDs and coils. However, data from Kwale and West Pokot counties indicate a preference for IUDs and coils. According to older married women, IUDs, coils and implants were viewed positively and often seen as useful and effective for ample spacing of their children.

"R2: Implants and IUD coils are mainly used by married couples." ***FGD-WP-Mature Women-300522***

"R3: Implants and IUD coils are mainly used by those who have families to help them with child spacing." ***FGD-WP-Mature Women-300522***

"R7: I would say that the most appropriate is the one I have used which is the implant for 3 years because once it was inserted I didn't get my monthly period but immediately after it was removed, it got my regular monthly periods. So I cannot say that it worked well or not but for me, I would say that the three years implant is the best because I used it but everyone has their own opinion, some have used three months of injections so everyone knows which ones work for them." FGD- ***KWL-Youth Women-01***

Contraceptive Use and Experiences of Women

Focus group discussion with female participants who were interviewed from the four counties narrated their experiences using contraceptives. Those who shared their experiences were married and had prior discussions with partners on contraceptive use. However, sentiments shared by rights holders pointed that contraceptives were not encouraged for those who are unmarried and young girls. Notably, unmarried young girls use of contraceptives was allowed by family members in unique circumstances such as when the young member of the family got pregnant and had a child. Under normal circumstances, young girls were not allowed to use contraceptives due to the perceived side effects and complications associated with contraceptive methods such as infertility.

"R5: use of family planning doesn't necessarily need to be married because there are some who get pregnant while not married. So once you have a child you can use protection, I mean, family planning but if you don't have a child, you cannot use it because you don't know whether God has a plan for a child or not. So it is not good to use family planning if you don't understand its use". ***FGD-KWL-Youth Women-01)***

"R2: Not all because there are those in the adolescent stage and might use family planning and have complications in future maybe they may use family planning which is good and may later develop complications in future if she had never had a child before". ***(WP-WRA-030622)***

"R8: The parents do so, so as to avoid her getting pregnant again just like the first time. This is mostly for school-going girls when they get pregnant before completing their studies. R8: At times, girls start using family planning at a young age when one of the elder sisters gets pregnant, thus the parent takes the rest of the sisters to get the injection so as to avoid them from getting pregnant." ***FGD-NRK-Youth Female 300522***

Secrecy and discrete use of family planning methods was prevalent and emerged as the norm for women whose partners opposed the use of contraceptive methods. This view was espoused by male engagement participants in West Pokot.

"R4: Because the husband or sexual partner can tell her not to use family planning because the husband or sexual partner wants her to give birth and maybe the woman sees that the man isn't responsible. So, the woman will be forced to secretly go and get family planning with the man knowing." ***FGD-WP-Mature Males MM-28072022***

"R2: They are afraid of being pregnant so they use it secretly to prevent pregnancy. You will find them asking for daily pills before having sex or using the injection." ***FGD-WP-Mature Young MM-280722***

Decision and Approval of Contraception Use

Evidence alluded from the FGDs (both women and men) reveal that most women and girls of reproductive age who were in a stable relationship often needed consent and approval from their partners to use contraceptives. However, it was reported by some women that it was challenging to seek permission from partners especially if the partners opposed contraceptives use. Thus, they went ahead and made individual decisions to secretly challenge their partner's authority to use the FP methods. Moreover, some women felt there was no need of seeking approval from their partners as they were the ones bearing the brunt of childbearing.

"R5: Yes, you have to seek permission because just in case you want to ask for money from your husband to put family planning: If you are married you have to consult your husband and if you are not you consult your boyfriend period" ***FGD-NRK-Youth Female 300522***

"R3: YES. It is a must to get permission from my husband so that he can tell me whether to use family planning or not. Many men believe that family planning destroys women's wombs not have children again and give birth". ***FGD-WP-Mature Women-030622***

"R:10 No, she could not seek permission from him because she might fear her husband will refuse to be a Somali she should go ahead and use it for herself ***(FGD-GSA-Youth 01)***

Abortion Practices

An emerging theme in the narratives espoused by both right holders and male engagement participants was on limited use of contraceptives by school-going girls due to inaccessibility of the FP methods. As such, a lack of contraceptives resulted in abortions being procured by young girls who viewed this strategy as a way of managing unintended or unwanted pregnancies..

"That is now the issue, that the girls who are between 12 years-20 years, she gets pregnant and then decides to abort, or even if she gives birth, she has no one to support her." ***FGD-NRK-Mature Men MM***

"There are traditional methods. There are some who use Aloe Vera, for abortion purposes. Tea leaves as well" Abortion was considered a traditional method of family planning. ***FGD-KWL-Mature Men-MM03***

"R3: In Kwale County girls could engage in unprotected sex ending leading to pregnancy and be left with abortion as a choice that now became a norm for young girls though despite being the community norms." ***FGD-KWL-Youth Mature-03***

Side effects

FGD right holders and male engagement of both gender described commonly known contraceptive side effects experienced by users. These include prolonged bleeding, obesity, joint pains, low libido, high blood pressure, dizziness during sexual activity and interference of menstrual cycle. For example some women lamented that injectables caused hypertension and they believed that using a coil can make one die while engaging in sex.

"R2 The problems that occur are when she uses family planning like injection they can cause menopause and also the absence of menstruation" ***FGD-GSA-Mature Men 01***

"R7: According to me the 3 months' injection causes high blood pressure" ***FGD-NRK-Mature Women FM2)***

"R2: Side effects of family planning are when there is menstruation of a woman she gets infectious diseases and sometimes bleeding also from menstruation, kidney disease also" ***FGD-GSA-Mature Men 01***

Contraceptive Discontinuation

Right-holder participants especially women indicated that discontinuation of FP use was primarily linked with fear of side effects, especially excessive bleeding while other women stopped because they changed their mind and wanted to have a pregnancy, while other women who had secretly used FP stopped because their partner found about their FP use. Other reasons for discontinuation were long queues at the health facilities, wait time to receive certain methods such as Norplant which required specialized clinicians and cost of service. Similarly, perennial stock-outs of FP led to discontinuation by young girls who reported that Femi-plan pills were occasionally not available. Among the Muslims, the major reason for discontinuation was related religious social-cultural undertones that resulted in negative perception of FP both by peers and family members who made women shy away from using contraceptives.

> *"R2: When one gets the side effects, for example when one uses injection during their monthly period they bleed a lot"* ***FGD-NRK-Youth Female*** *300522*
>
> *"R3: you have to use transport cost to get there and when you get there, there are queues. So you queue there until 4 pm then they close the health facility and you have to use another 100Ksh as fare and return back. When you get back, you get demoralized and give up because you went there the previous day and missed that service."* ***FGD-KWL-Youth Women-01)***
>
> *"R8: Once you get there you find that your method of choice for family planning is out-stock and they tell you until next month or after 5 months. So when you go back home, you will be demoralized and give up."* ***FGD-KWL-Youth Women-01)***

Barriers to Contraceptive Use among Women and Girls

Majority of FGD participants (mainly Women and girls of reproductive age, users of contraceptives and of men) opined that contraceptive access and uptake in all four counties resulted from lack of access of the preferred contraceptives. Whereas, utilization, and uptake had individual devastating impacts on women's health and well-being. These barriers were common and overarching across Narok, Kwale, Garissa and West Pokot.

Access to Contraceptive Challenges

First, it's worth noting that different forms of Family planning methods exist and were available at the different service delivery points in both rural or urban settings. However, contraceptive users reported difficulties accessing their preferred methods due to the distance and location of facilities which mostly disadvantaged women and girls who had not disclosed contraceptive use to their sexual partners. Long wait time and associated loss of time while at government facilities was also a barrier reported by most women interviewed.

> *"R5: One of the barriers is the inability of the facilities in our community. Now that if someone wants an implant or coil they have to go to Msambweni County Referral and if they miss it there or are out of stock, they are forced to go to Kwale Sub-county hospital*

or even to Mombasa County. So someone weighs the charges…the fare becomes difficult." ***FGD-KWL-Mature Women 03***

R6: Accessing family planning methods are expensive to buy, transportation cost is also expensive and the distance is far. ***FGD-WP-Mature Women-030622***

Other barriers narrated by FGD discussants especially those in Garissa and West Pokot counties recounted negative provider attitudes and a lack of confidentiality among the health care providers. Participants reported that some health workers inadvertently disclosed their contraceptive use to their partners.

"R8: Age is a factor, in this community under 18 years and young girls are criticized by health workers when they go to seek family planning." ***FGD-WP-Mature Women-300522***

"R7: to add to what R8 has said, the lack of friendly nurses is a factor leading to criticism." ***FGD-WP-Mature Women-300522***

"R4: She cannot use contraceptives without her husband's knowledge because if she goes to the health facility in Garissa and wants family planning the first thing is the doctor will ask her to go and negotiate with your husband." ***FGD-GSA-Mature Men-01***

Other factors that impeded access to FP among women of reproductive age across counties, especially in West Pokot and Garissa included religious beliefs, social and cultural beliefs, community perceptions and negative attitudes from partners.

"R8: Cultural beliefs in the community are that a woman is perceived her job is to bear as many children as she can in this community." ***FGD-WP-Mature Women-300522***

"R3: Fear of divorce if your spouse does not like the use of family planning methods." ***FGD-WP-Mature Women-300522***

"R1: According to me, it is not allowed in the Somali community because it seems to encourage one to practice sex because one cannot get pregnant. For example, when one gets that injection of 5 years, she is assured she won't get pregnant until the 5 years' elapse." ***FGD-GSA-Youth 01***

"R9: It's not good because we as Christians our religion do not accept family planning even if we said circumstance, there is no circumstance in the bible it's forbidden for instance in Christianity we believe don't use a condom when you have your wife or husband if you are married is not acceptable." ***FGD-GSA-Mature Men-01***

"R7: from the religious point of view it would be hard for her to continue using Family planning, she will discontinue because we Muslims follow the footstep of our swahaba (followers of prophets) and prophets said go and marry so that my Umah (people) will be

many so if she never heard that and then hears she will discontinue the use of contraceptives." ***FGD-GSA-Mature Men-MM***

Motivation for Contraceptive Uptake

Understanding the decision-making pathway and why contraceptives are used by women of reproductive age is essential to better understand modern contraceptive use trajectories. One underlying reason that influenced FP use is the prevailing economic conditions that drive users to having fewer children to enable them to enhance their quality of life through good education and nutrition. The prevailing economic situation largely contributed to the uptake of Family planning and aided the decision making process by users mostly with or without the consent of male partners.

"R10: You can have your partners whom you have been having children with but is not supportive. So in such a case you can get advice and go straight to the hospital to get family planning because he just gives you a child and disappears leaving you alone to raise the children. So there can you can get advice and go to the hospital to get family planning." ***FGD-KWL-Mature-01***

"R6: Someone in marriage might use 3 years of contraception to allow the baby to reach 3 years after which she may decide to get another baby. Nowadays one cannot give birth to too many children because now children come with a lot of responsibilities. A child requires education and clothing, so it depends on your financial status on the number of children you can take care of." ***FGD-NRK-Mature Women FM2-040622***

"R6: The child needs to eat well, be well clothed and get a good education because if you don't use family planning you will have a lot of children and some will never go to school…they will stay at home…. maybe 7 children will have no food, fail to go to school/ lack of education and stay at home and that is not good having that kind of life. They will lack school fees and hence stay at home, with no food for them, and clothing is a problem. So it is better to use family planning so that you can space your children or have a plan because of hard economic times so that children can get an education rather than staying at home." ***FGD-KWL-Mature-01***

Changes in Family Planning Perception

Evidence from the FGDs shows that there were changes in perception towards the use of family planning. Changing positive trends in contraceptive use among women of reproductive-aged were noticeable and reported to have occurred over the last 12 months in Narok, Kwale and West Pokot. Women appeared to be seeking family planning methods more owing to the social behavioral interventions such as SBCC that promoted young girls education, and male engagement to reduce negative perception of family planning and ensure education and information awareness was delivered in a multi-sectoral approach. Importantly, most

contraceptive users who cited increased awareness of contraceptives and a reduction in negative attitudes towards contraceptives were decreasing among men.

> *"R5: It has improved because Men in this community have knowledge of modern contraceptives and child spacing has improved."* ***FGD-WP-Mature Women-300522***

> *"R1: There are a lot of changes because, in the last 12 months, many women were giving birth without planning their families and yet they don't have money that would take care of their children so they become sick and don't go to school but now the use of family planning has made children become healthier as some have like 2 children who are well spaced and they can take care of them well, and get a good diet."* ***FGD-KWL-Mature-01***

> *"R1: What has led to the changes; in the past when a woman gives birth, a sheep is slaughtered and the woman drinks the fat, also the baby only required a little clothing and the baby was still healthy. But now when a woman gets pregnant, she goes to the hospital before her Labour and the baby is delivered through caesarean. In the past, a cow would be speared on the neck for blood to come out and the lady would be fed with that blood, but now such things are no longer possible. Now when a baby is born, they require things like towels, the mother also has to go to deliver in the hospital, and all that requires money. So now where do you get all that money, to cater for the need of many children? Also, there is education, that the educated people want the best for their children, to take them to the best schools. So if you give birth to a big number of children, would you be able to take them to those schools? Also in the past herbs were used as tea leaves to prepare tea herbs called Madida, but now kids don't want such. Now they can't take tea without bread, such things, so those are the things that have led to the use of contraceptives and change."* ***FGD-NRK-Mature Women FM2-040622***

Despite social-cultural norms and religion being identified as obstacles to access, utilization and uptake of contraceptives, it emerged that community's perception and attitude were changing towards embracing contraceptives. Younger men appeared to be increasingly supportive of their partners FP use compared to the older men who were still skeptical about their partners use of contraceptives.

> *"R8: The younger men have embraced contraception, the older men 50+ are the ones who are not embracing the use. R8: But even some of the older men have started embracing the use of contraception, so their attitudes have changed compared to the past."* ***FGD-NRK-Mature Women FM2-040622***

> *"R4: It's better because people didn't contraceptives before but nowadays it become good and even others are using them publicly without fearing."* ***FGD-GSA-Mature Men-01***

Male Engagement in Contraceptives Discourse

Male engagement FGD participants shared useful perspectives which described FP choice pathways. Most participants concurred that they use their preferred FP method based on their relationship status. For instance, married men opted for long-term contraceptives, while the younger adults opted to use short-term contraceptives. Implants and condoms were the most common FP of choice among the married males, while P2 was preferred choice of FP young men. Use of two different methods was largely dependent on the relationship status. Women who were married or cohabiting, made decisions on the use of contraceptives for child spacing to prevent against unwanted pregnancies.

> *"R8: For me, I can say yes where I come from in my community, there are these cases whereby we have teenagers having pregnancy, so we normally advise that because of peer pressure those kids who are at school may be in primary or high school, they have that peer pressure, they just feel like doing it, so is better they use a protective measure like of condom to prevent; first sexual transmitted infections and HIV/AIDS and pregnancy."* ***FGD-GSA-Female Young MM002***

> *"R6: Emergency pills {P2}. In fact, we are the ones buying and giving them to take these pills."* ***FGD-WP-Young MalesMM-280722***

> *"R6: There is an agreement between couples. It is hard to plan for the first child because you might get yourself having the first child without planning. After having the first child, you have to talk to your wife and tell her that you don't want to get another child at this time. I want to have to another child after maybe 5 or 3 years or even 10 years. So, you have to talk to your wife and go to the hospital where there are different family planning injections. I will tell the health practitioner that I want my wife to be given a family planning injection for 5 or 3 years because I don't want to have another child at the moment."* ***FGD-WP-Mature Males MM-30072022***

In some instances, participants reported that sexual partners made a joint decision to use family planning methods. The discussion mainly revolved around how they would prevent unwanted pregnancies in view of the existing economic environment and schooling for the children.

> *"R6: Yes. People who are dating or married, their wives/girlfriends involve them because they don't want to have a child yet or many children when the other children are still young.* ***FGD-WP-MalesYoung-MM280722***

> *"R5: It is not a must that the wife is the only one asking for family planning permission, the man can also decide that right now he is not stable so he has to talk to his wife about the use of family planning and accompany her to the hospital."* ***FGD WP-Male Young-MM280722***

> *"R1: Yes, I can discuss with my partner to have family planning because of our circumstances because I am in school and he is not financially stable we can decide to use family planning in a certain period of time so that we can plan out a livelihood, I say yes.* ***FGD-GSA-Female Young-MM002***

Conversely, it emerged from the male engagement sessions that there were circumstances that hindered men from supporting their partners to use family planning methods. The reasons were underpinned by deep-seated social-cultural norms, and religious beliefs that were fronted to bar women from using FP.

> *"R1: I am a Pokot and our tradition does not allow family planning because when we marry, we marry to have many children."* ***FGD WP-Male Young-MM280722***

> *"R5: There is a contradiction because the most populated people with many children are those from the reserve. However, here in urban areas, people have been enlightened to use family planning. So you will find in the reserve areas, young girls like 13 years are pregnant just because the tradition geared by the elders does not promote family planning."* ***FGD WP-Male Young-MM280722***

> *"R8: In my community belief that is unacceptable to use family planning based on religious reasons because family planning is not allowed."* ***FGD-GSA-Female Young MM002***

GBV Perspectives: Right Holders and Male Engagement

GBV Knowledge and Perception

Both right holders and male engagement interviews demonstrated awareness of the conflicts taking place in their communities. In particular, it was reported that GBV was common in the community and often perpetrated by known family members, community members and sexual partners. The most common forms of GBV included intimate partner violence (IPV), early marriages, female genital mutilation, and rape. Some participants affirmed to have witnessed these types of violence happening in the community.

> *"R: For female genital mutilation, mostly parents are the ones making the decisions for the child to undergo female genital mutilation."* ***FGD-GSA-Female Young MM002***

> *"R3: it happened that the woman went for family planning without telling the husband. So what followed next, was the husband later realized the issue and he wanted another child. And now the mother had gone for family planning without involving the partner. so now the time when the man wanted a child, he noticed that the wife had gone for family planning without telling him. So it brought quarrelling and fighting with her husband and the woman escaped to her parent's home."* ***FGD-NRK-Mature Males-010622***

> "R10: *I have heard so much about FGM which is not too much in Pokot but when you go down to murkowen sook,,,now they are saying when a girl is not initiated she is valueless to the family and community in large ,,,,,,,at our place there is none but issues to do*

> *with raping is there. When someone is raped it leads her to a lot of stress because you may be impregnated and the person responsible dashes away so these are illegal cases"* ***(FGD-WP-Mature Males 3106522)***

Generally, women narrated seeing other women being subjected to violence. They affirmed that women were more likely than men to be victims of gender based violence especially sexual assault/sexual violence or domestic/physical abuse. Compared to men, women had a higher odd of experiencing intimate partner violence. Children on the other hand, experience violence through physical abuse, sexual abuse, and child labour.

> *"R3: I see mostly the perpetrators are the boys because you cannot find a young girl and say she was raped by a fellow woman. So perpetrators are the younger males and older males."* ***FGD-NRK-Youth Mature-MM***

> *"R8: In our Somali cultural traditions of arranged marriages can also contribute to violence because you have known to each other, it is not your choice, you have just brought to each other and even don't even match each other."* ***FGD-GSA-Mature Males-MM***

> *"R1: Girls because of forced early marriages because the parents believe that educating girls is a waste of money."* ***(FGD-WP-Mature Women 030622)***

> *"R4 Girls because of forced early marriages for the parents to obtain money from dowries."* ***FGD-WP-Mature Women 030622***

Notably, women were also among the main perpetrators of early marriages in West Pokot. The analysis shows that women commonly married off their daughters aged between 13-24 years for monetary gains with an aim of supporting other younger children as depicted in this quote;

> *"R6: Women mostly because they force girls to early marriages to obtain money for basic needs and to educate the younger siblings."* ***FGD-WP-Mature Women 030622***

Acceptable Circumstances of Violence

Participants reported that sexual violence and domestic violence were the most common type of violence that women were subjected to in the community. The main reasons women experienced violence was because they were disrespectful to their partners, leaving home without their partner's permission or refusal to have their children punished.

> *"R2: Some women in some house you find she is the one who is on top and the husband is down. She is the one who gives the final say in the house. So when you hear she has been beaten in the house, people say that's good punishment it has been done well."* ***(KWL_RH_FGD_MW_02)***

> *"beating is allowed for example I have a wife who is supposed to stay at home and I come home at night and find her missing maybe she has gone to the drinking dens; there I will be forced to discipline her"* ***(WP-FGD2-3106522)***

In West Pokot County some men were subjected to violence by women. When such incidents occur, the perpetrators would face the wrath of the community by being sanctioned by community elders, paying hefty fines or suspended from conducting community affairs. Besides, the affected homestead would undergo cleansing per the Pokot cultural practices.

> *"R1: Yes, there is, the man's family will gather together, talk to the woman, pay a fine to the man's family and carry out some rituals because it is an abomination in this community."* *FGD-WP-Mature Women-030622*

> *"R2: Yes, then the woman is suspended from the community."* ***FGD-WP-Mature Women-030622***

Intimate Partner Violence

Both male engagement and rights holders averred that intimate partner violence is a sensitive subject, which was rarely discussed or reported by married women. Reasons for marital violence varied and ranged from non-consenting forceful sex, refusal to provide conjugal rights, and suspicion of partner's infidelity. The below quote demonstrates divergent views shared by the participants on marital sexual violence.

> *"R6: If the woman is hard-headed and does not even listen to her husband. She does not care who is who. So when you see she has been beaten you will say the husband has done well. Because even…*
> *(Cross talk between R6 and R7)*
> *"R7: If she does not listen to the husband it is like she is the husband in that house. She does not respect anyone. Even she does not respect her neighbours. You will find when she is beaten you celebrate …****FGD-KWL-Mature Women 02***

> *"R3: That is your husband and he has married you, you are in that house together. Even if you are tired you will have to up your sleeves."* ***FGD-KWL-Mature Women 02***

> *"R4: No, she should not refuse to offer sex to her husband since he will go seek sex outside marriage and that will lead to domestic fights****." FGD-WP-Youth Women-030622***

Male engagement discussants from West Pokot's dismissed the aspect of rape within a union. The reason is that with or without consent women who are married should be respectful of their husband's sexual requests as underlined by the cultural norms.

> *"R8: No, it is not rape because you have been in marriage for a long and it is all about agreeing when to have sex and when not to have it."* ***FGD-WP-Youth Women-030622)***

Violence Disclosure Pathways

Participants reported channels for which survivors of violence would report cases of violence and disclosure pathways. From the FGDs it appeared that girls would disclose episodes of sexual violence to their mothers, sisters, or best friends who would then move ahead and escalate the matter by reporting to the relevant authorities. This view is demonstrated from the quote below;

> *"R5: Her mother. She will first start with her mother then the mother will tell the husband."* ***FGD-KWL-Young Women 01***

> *"R2: She tells to her parents the right statements from the police and then report to human rights or children departments"* ***FGD-GSA-Mature Males 01***

In Garissa County, which is predominately Muslim, incidents of violence were commonly communicated/disclosed to religious leaders. Whereas, some girls lacked the courage to disclose experience of sexual violence to anyone. Hence, they take matters into their own hands to address any adverse outcomes of violence by for example obtaining emergency pills to prevent unwanted pregnant. Fear of being excluded in the community and self-stigma made youngest women hide in view of the strict religious edicts that uphold the sanctity of virginity before marriage.

> *"R6: they use emergency pills to protect pregnancy for not disclose rape to someone since the rape will hinder from being married in the future that's why they use the pills"* ***FGD GSA-Mature Youth01***

Access to GBV services

Participants reported that care-seeking services for survivors of violence occurred at health facility settings. The care package for GBV at the facilities entails counseling services, sample, and legal evidence collection. Although these services were available, in most instances survivors of sexual violence were reluctant to report the incidents to relevant authorities and instead would self-medicate to avoid shame, guilt and stigma associated with being raped.

> *"R2: They will not seek medical care in the hospital …most of them go to the chemist. If they go to the hospital, they are asked their age and whether they have a child or not or why they want to use family planning"* **FGD-KWL-Youth Women01**

> *"R7: After she discloses to her mother, she would then take her to the hospital, but the problem is when she doesn't disclose because you can't know. Yes, nowadays rape cases are presented to hospitals so that the girl can be tested and treated"* **FGD NRK-Female Mature MM**

Participants felt that healthcare facilities were not providing comprehensive quality services due to a perennial shortage of essential medicines and medical equipment at the point of care outlets. Some participants noted that healthcare providers lacked trauma counseling skills and occasionally lacked basic instruments for evidence collection.

> *R2: You can be attended to at the hospital for free but you have to go buy medicines at the chemist because most of the time the district hospital does not have medicines. You get doctors who attend to you nicely but they don't have medicines to give you thus you are forced to go buy them elsewhere* ***FGD-NRK-Female Mature-020622***

FGM Perspective

Participants reported that FGM practice was still rampant in Narok and West Pokot where young girls underwent the vice. The reason for taking the girls for FGM was to prepare them for marriage as those who were not circumcised could not be married. The below quotes captures the FGM practice in Narok and West Pokot.

> *"R3 Yes, it is acceptable because it is believed that no man can marry a girl who is not circumcised."* ***FGD-WP-Youth Women-030622***

> *"R8: I hear that there are some who undergo FGM, and once the girl undergoes it she becomes ready for marriage."* **FGD NRK-Female Mature MM**

Post-Sexual and Gender-Based Violence Actions

Right holders and male engagement participants were both asked to provide their perceptions around SGBV reporting pathways in their communities. The narratives show that women who were knowledgeable or had prior experiences with SGBV reported the reporting procedures which started with informing the village chairman or the local chief, who later escalates the case by informing the law enforcement officers, and thereafter the perpetrator would be arrested.

> *"R4: You can go report to the police. Report to the chief. You go report so that everyone can get justice."* ***FGDKWL-Young Women04***

> *"R2: Mostly what they do is we conduct a (Maslaha) court of association of Somali elders and the individual does not favor the survivors or the perpetrator including their parents too****." FGD-GSA Female Mature ME 002***

> *"R2: First you would tell his parents. Second, you would go to The Chairman. And now from there is what we have discussed, if you give him something, then he will call the police and the police will come and follow up with him. They will arrest him and throw him there and they will ask him the mistake he has done. Then it will be dealt with just like that"* ***FGD KWL-Mature Women02***

Evidence from the FGD demonstrates that some survivors of SGBV realize a measure of justice when the perpetrators are taken to court, or pay hefty fines imposed through the *Maslaha* courts that are common in Garissa County. A common view by most participants was that more often than not survivors of justice receive justice.

> *"R7: They help a lot. They help a lot because everyone will get justice. If you have been abused, you will get justice and the person who has abused you will be condemned. You have gotten your right as a member of the community."* ***FGDKWL-Young Women04***

In some cases, as reported in Narok and Garissa County, the community elders or village courts were deemed to be obstacles to attaining justices. The local elders still uphold patriarchal beliefs and would suppress women voice their concerns. This hinders the dispensation of justice to the survivors of SGBV.

> *"R7: Justices only prevailed if concerned people survivors seek justice through the human rights avenues but if the matters are handed over to community elders, automatically case will end there."* **FGD GSA Female Mature ME 002**

> *R4: I can also say that women have not accepted the norm to be beaten but once you fight or you are beaten and old men come to listen to the cause of the fight or why you were beaten the woman is not given a chance to explain and the mistake befalls on her eventually. Even if you go, let's say to your brother-in-law, they will just return you back to your house. Thus a woman just learns to persevere with whatever she is going through in marriage.* **FGD-NRK-Female Mature-020622**

With respect to health care seeking services, participants felt that healthcare facilities provided inadequate services due to a shortage or lack of basic essential medicines and medical equipment. Also, participants lamented that healthcare providers lacked trauma counseling skills and basic evidence collection instruments.

> *R2: You can be attended to at the hospital for free but you have to go buy medicines at the chemist because most of the time the district hospital does not have medicines. You get doctors who attend to you nicely but they don't have medicines to give you thus you are forced to go buy them elsewhere* ***FGD-NRK-Female Mature-020622***

Barriers to GBV services

Nearly all the respondents said that corruption and fear were the major barriers to seeking care for sexual and gender-based violence. Lack of transport to the GBVRC Centre's and finances to obtain legal representation prevented the survivors or their families from seeking justice.

> *"R2: Lack of transport to get to the reporting centre."* ***FGD-WP-Youth Women-030622***

> *"R 4: Lack of finances to seek support from the authorities."* ***FGD-WP-Youth Women-030622***

> *"R2: the person will think that if they go to the hospital or the police station and if the person who raped her is someone who is known in the community. Maybe if they are taken to the police, they will be arrested. Maybe if you tell someone like a friend or a parent that you want to go to the police station, they will tell you not to go because he will be arrested and sentenced. So do not go forward with the case and they will solve it in the house either as a family or a community"* ***FGD KWL-Young Women04***

While at some individual level girls from the Muslim communities feared being identified as survivors of sexual violence or else they would be stigmatized for breaking their virginity and jeopardize getting marriage. Similarly, right holder and male engagement participants observed that self-stigma and self-doubt likely affected survivors of SGBV.

> *"R6: It is acceptable in the law for one to get her rights. It is just that we have fears within us which prevent us from seeking justice. Probably men know that we women don't know that we have rights that's why they oppress us."* ***FGD-NRK-Female Mature-020622***

> *R6: Issues like this happen in this Cushite community we are living with them, if a girl happened to be in such an incident of rape, even if she goes to school, she may not have the confidence to talk with her peers, likewise, and during the marriage, nobody will want to marry her because she was raped and she will not be given her right.* ***FGD GSA Female Mature ME 002***

Key Informant Findings from Male Engagement Interviews

Knowledge of contraception

Most informants' participants in Narok and Kwale revealed conflicting opinions on the use of family planning by women. Some believed that the difficult economic conditions in Narok had led to the adoption contraception to allow them have small families that they could easily manage.

> *"R: Yes especially the youth have embraced the use of family planning. The reason being is the harsh economic situation and you see the Maasai of today are different from the past years nowadays it is only the name Maasai that doesn't change, the character and behavior has changed drastically".* ***NRK_ME_KII(CL)_DS.docx***

> *"R: Just supportive because of the huge responsibilities that come along with big families …they are supportive. Nobody would want to go through the burden of bringing up a big family"* ***KWL_ME_KII(AC)_EW.docx***

Despite the fact that some men in Narok and West Pokot had begun to embrace family planning and desired smaller families that they could support, resistance to contraceptive use was enhanced by concerns around infertility, lack of pleasure during sex that commonly resulted in divorce or separation, promiscuity, infertility, and changes in the physiological makeup of the women.

> *"R: I can say most men do not like though they may wish to get a family which they can fully sustain. Once they know that a woman is using family planning, they believe that the woman is having affairs outside of marriage. Also, men believe that methods of family planning make women grow big or add weight or others get so slim and others believe that once a woman uses family planning she cannot be able to get children in future"* ***NRK_ME_KII(RL)_AP.docx***

> *"R: There are some that's why men don't agree women use family planning because it promotes prostitution"* ***WP_ME_KII(MVE)_JK.docx***

Most men in Garissa were also against contraceptives for cultural and religious grounds. In most instances, a divorce would occur if a wife used contraceptives without her husband's knowledge. Thus, ignorance, societal norms, and religious convictions, underpinned men's resistance to the use of contraception.

> *"R: One is religion, two is culture, three the partners always reject the idea even if they tell the partner about it that can lead to divorce"* ***GSA-ME-KII(Teacher2)-AO.docx***

Contraceptive Usage: Facilitating Factors

Men in Garissa did not support the use of contraceptives, although they did let women and girls use them in some situations. These included cases involving rape, caesarean sections, a high cost of living, and poor health conditions, as documented in the quotes that follow.

> *"R: Especially in this, certain future we are facing because fornications have now spread it even the rape of the girl's defilements and all these things that is one something like that enquired and a girl has been raped or something like that is very important for her to use family planning to stop that what we called unnecessary pregnant to come with her without consent."* ***GSA_ME_KII(RL1)_YM.docx***

> *"R: Because the cost of living is high."* ***GSA_ME_KII(CBO1)_RN.docx***

> *"R: Most of the Somalis are been forced to take this family planning because of caesarean operation so when they give birth this will force them to use in order to make the long period between the next giving birth."* ***GSA_ME_KII(RL1)_YM.docx***

While in Kwale, the majority of males supported using contraceptives to promote the child's growth and development, which would eventually result in improved health outcomes for both the mother and the child dyad. The younger age groups also utilized contraceptives to protect themselves against STIs and unwanted pregnancies.

> *"R: They will have that time for spacing their children if they use family planning. Firstly, the child will grow well… the outcomes for the child will be good. To the man, you will have to manage your responsibilities well for the woman or even yourself for the benefit of the child. You will be very responsible, unlike someone who doesn't do family planning."* ***KWL_ME_KII(CHV)_EW.docx***

> *"R: In this generation when you talk of the young generation they find it good because it …two ways one is that you are protected from getting infected with STDs (Sexually transmitted disease and such things, secondly unwanted pregnancies or unplanned."* ***KWL_ME_KII(AC)_EW.docx***

Due to scarce resources, such as land, and the tough economic situation, some participants in Narok believed that most men supported the us of contraception and desired to have smaller families that they could easily manage.

> *"R: There is an issue of land too, you'll find that the size of the parcel of land has reduced for example I have like thirty acres, if I divide with seven children it is a small land. So the educated community members see that getting many children will be harder to raise because the children will need education, and food and there are no employment opportunities. So they need to plan the number of children to have a better life."* ***NRK_ME_KII(CL)_DS.docx***

Side effects of Contraceptive Use

In Kwale, West Pokot and Narok women and girls were given permission to discontinue family planning if they encountered side effects such as excessive bleeding, weight gain or loss, hypertension, miscarriage, low libido, sleep problems, chest problems or dizziness. More so, certain types of contraceptive methods such as pills, Depo, Jadelle, and IUCD were associated with the aforementioned side effects.

> *"R: Like the pills, if you forget to take them you get into trouble and also bleeding during the monthly periods. So pills and injectables have that challenge of bleeding throughout".* ***KWL_ME_KII(CL) _EW.docx***
> *"R: some refuse to use other methods like Jadelle Implant because it makes them gain weight or lose weight".* ***NRK_ME_KII(CHV2)_DS.docx***

> *"R: There are issues like blood pressure among women. There are women who go about prescribing a contraceptive like for example Depo instead of the coil and maybe their*

body is friendly to the coil. So they may end up like bleeding, miscarriage and more bleeding during periods so those are some of the issues". ***NRK_ME_KII(CBO2)_DS.docx***

Male Involvement Views on Condom Use

Most men in Narok did not perceive condoms favorably for its dual role of pregnancy prevention and HIV/STI prevention due to a number of reasons which includes ignorance, feelings of shyness, the social and cultural norms and the belief that condoms would remain inside the woman. Furthermore, the young men and boys disapproved of the usage of condoms and believed that those who used them were unfaithful to their partners.

"R: In this community, they do not like it, the youths say they want to "Eat it that way and this attitude we want to change so that they know as long as it protects pregnancy it also protects against other diseases. So they're changing slowly because of STIs but previously they never liked it". ***NRK_ME_KII(CHV2)_DS.docx***

"R: A few use it and encourage others to use the condoms too, but as a method of protection from STIs and STDs since they're unfaithful and not use the condoms as a way of protecting women from pregnancies" ***NRK_ME_KII(CBO2)_DS.docx***

Due to increasing awareness, particularly among older males, some participants in Kwale reported that men had a positive attitude toward the usage of condoms. The older males adopted condom usage, notably for preventing STIs and unwanted pregnancies. However, there are others who indicate a lack of pleasure during sex and frequent condom bursts, particularly among young men.

"R: For male condom use I can say there are two groups; the first group likes condom use because they were taught and understand the importance of family planning and they know if they use condoms they can protect themselves from diseases and other things but there are other because of culture who says that if I use condom there would be no pleasure unlike when there isn't, others say they can use a condom and burst thus causing a lot of issues. So these are the attitudes here in the community".
KWL_ME_KII(CBO)_EW.docx

In Garissa most men believed that those who used condoms had HIV/AIDS, were unclean or were involved in extramarital affairs. Furthermore, condom usage was prohibited by the Muslim faith.

"R: They upon accept because when we think about giving/ there was a time the government were giving condoms some putting in a place that you can collect but you know is like when we are using condoms sometimes people think many people we have talked with them or give them counsel to guide them, they think when you use a condom may be one is affected AIDS or have diseases or STDA or STDI" ***GSA_ME_KII(RL2)SA.docx***

"R: Negative, Very negative. They believe it is, it is against, and it is against the book of Koran. So mostly they don't use it" ***GSA_ME_KII(Teacher1)_YM.docx***

Barriers to Family Planning Use

Some women in Narok, Garissa, and Kwale did not utilize family planning due to cultural beliefs, and the stigma associated with contraceptive users being perceived as promiscuous. Additionally, FP usage was perceived to contradict religious beliefs and resulted in infertility hence most women were discouraged from using them. At the same time, several women who used the IUCD stopped using it after their husbands reported being pricked during intercourse.

> *"R: Emanyatta is where all men of a particular age set together with their women assemble occasionally and have traditional customs in the community. So at the Emanyatta someone maybe be cursed if they end up using the Family planning method and are directed to have as many children as they could"* ***NRK_ME_KII(CBO_DS.docx)***

> *"R:Apart from seeing her as a prostitute the community will see the man whose wife has used family planning as the man has been controlled by the wife and the wife is superior to the man".* ***NRK_ME_KII(CL)_DS.docx***

> *"R: As in there are …there a time a lady went for that family planning then while they were having sex with her husband, the husband complained of being pierced while having sex until it reached a point where she had to go for removal of that family planning method. So there is that belief of the man that when the wife uses family planning there is something which is going to happen and so many don't use like it".* ***KWL_ME_KII(CHV)_EW.docx***

Opportunities to Engage Men and Boys in Family Planning

Participants in Kwale, Garissa, West Pokot, and Narok reported that men took part in family planning discussions only when women asked for permission to use family planning. Men, for instance, were included in family planning discussions since they were the family's heads and were the first to provide assistance in the event of any emergency or adverse effects.

> *"R: Yes, they believe because a man should be involved in family planning decisions and so it is a must for them to give permission."* ***KWL_ME_KII(CHV)_EW.docx***

> *"R: The women have to get permission from the men for them to use family planning."* ***GSA_ME_KII(CBO2)_AO.docx***
> *"R: That one it supposed to be. But a woman needs to talk with her partner because she may get a contraceptive that will affect her in one way or another and your partner will be the one to help you so it is important to discuss."* ***NRK_ME_KII(CHV2)_DS.docx***

GBV Knowledge and Perceptions

Girls in Narok, Kwale, and Garissa were more likely to encounter gender-based violence, such as forced marriage, FGM, and early marriage. The boda boda riders also took advantage of young girls situation by offering free transportation to and from school as well as buying for them sanitary towels in exchange for sex.

> *"R: My reason to say that is because, girls of that age lack enough education and if they stay at home they are exposed to threats such as undergoing FGM, and early and forced marriages because they do not have anything they do at home and parents do not look for ways to take them back to school, they see that marrying her off is better"* ***NRK_ME_KII(CBO1)_AP.docx.***

> *"R: So might find that these school girls, for example, don't have sanitary pads, also they lack transport to and from schools and the parents can't afford to these situations make the girls vulnerable for example to Boda Boda guys. So poverty contributes a lot".* ***KWL_ME_KII(CBO)_EW.docx***

Due to poverty, women and girls in West Pokot were particularly vulnerable to gender-based violence, FGM and intimate partner violence.

> *"R: Mostly these girls come from the poor background they do not have the decision they are dependent on people., they are vulnerable to FGM, and partner violence and also they can afford a lawyer most of these cases are not handled well because of their status so it ends up not being reported, it kills the morale of women reporting this cases"* ***WP_ME_KII(CBO1)_FC.docx***

Perpetrators of Violence

Participants in West Pokot, Garissa and Narok indicated that parents largely encouraged their daughter to undergo FGM and forced marriage. In some instances, the parents were singled out as perpetrators of of these two vices. However, in Kwale most perpetrators of the gender-based were relatives, truck drivers, and *Boda Boda* riders.

> *"R: For the FGM the perpetrators are the parents because there's no way someone else will come from nowhere to a village and give out a girl or a woman to undergo female circumcision no. That is an agreement between the parents and the community because they are those elders come together to discuss on what to do on a particular day for instance asking themselves how many girls have reached that age to be circumcised. They look at the age and decide the girl is ready to be circumcised and get married".* ***WP_ME_KII(Teacher1)_JK.doc***

> *"R: In most violence, it is the men and old women. On the side of FGM, you may find a man who says he cannot marry off her girls without them undergoing the cut. Thus he will come and force the wife to circumcise the girls and if the wife refuses, it will violence and if the wife agrees and the daughters disagree to it, it will also be violence between the parent and the girls. The old women on the other side still follow the custom whereby they say their children, the children of their children will have to undergo the cut. Thus they will force the mother to circumcise her even against her will"* ***(NRK_ME_KII(AC)_AP.docx)***

*"R: Relatives like uncle defiling or cases of incest or blood related cases. Also Boda Boda, driver truckers since Lunga lunga border the Tanzania and even the palm harvesters". **(KWL_ME_KII(Chief)_EW.docx)***

Male Violent Partners

The main drivers of violence meted at women included poverty, alcoholism, drug and substance abuse. Men were also said to be involved in marital rape because their partners denied then their conjugal rights.

*"R: Poverty, for example in a homestead, let's say you find those men who do not provide anything like they bring nothing to the table and then they come forcing their wives to bring food and the wife has nothing to bring." **NRK_ME_KII(CHV1)_AP.docx***

*"R: Another one is alcoholism also contributes. You know when you are drunk you become violent …you tend to be violent. You do something and then regret it late when you are sober but it is too late. So alcoholism also contributes to that."**KWL_ME_KII(AC)_EW.docx***

*"R: I can say being under the influence of drugs or being drunk but for men who do not abuse drugs and violence it could be due to the High economy or cost of living and the wife is pushing her to the walls to provide for the family so the husband ends up being irritated, angry and beating his wife. Women also Influence these men to be violent because when they need something they command and many men don't want Women being above them so they decide to beat them up." **WP_ME_KII(RL)_JK.doc***

*"R: Circumstances where you want to have that intimate relationship with your woman or wife and she denies you that. When you enter her by force."**(GSA_ME_KII(CL1)_RN.docx)***

Female Violent Partners

Some of the reasons that contributed to aggression by women includes psychological abuse, painful sex due to FGM and poverty.

*"R: you may find that there are some women who are so demanding and every morning they just want something and maybe whatever the man has is very little, thus this man gets psychologically disturbed". **NRK_ME_KII(RL)_AP.docx***

*"R: You know FGM play place a very big role because a man needs a woman and FGM because she passed she always sees that sexual intercourse is a pain to her" **GSA_ME_KII(RL1)_YM.docx***

*"R: you know the man is expected to provide for the family but then you find that he doesn't have a job yet the family is looking at him to provide …when he comes without money then the women will start engaging them in anger thus resulting in violence. So lack of employment contributes a lot to that" **KWL_ME_KII(RL) _EW1.docx***

Participants said that the community members developed their own strategies to address gender-based violence. For instance, women and girls were educated on what to do in the event of a violation. Similarly, CHVs, as well as religious and community leaders, organized forums to raise awareness of the effects of GBV.

> *"R:Yes, they have responsibilities because like the religious leaders, they normally do seminars like in the churches you might find the pastor educating the people or on Fridays you might find the Imams educating the people and in the community there are village elders meeting and the nyumba Kumi where the CHVs come to educate the community-…the parents and the community so that the cooperation between the CHVs and community leaders becomes even better for the children at home"*
> ***(KWL_ME_KII(VE)_EW.docx)***

Participants alluded that teachers and community groups routinely discussed sexual and reproductive health matters with girls in formal settings like schools. However, they did not discuss the use of family planning owing to the sensitivity of the matter and cultural beliefs.

> *"R: There are some groups of community organizations which just go to the schools to talk to the teenagers, the teacher also talks to the teenagers just about their productivity but not about the use of family planning because if we try to mention the use of family planning to the children … to those girls of 17…13, 14, 15 to 17 years, somebody who is below 18 years,… the community, in the community you will be like an outcast because you are giving false information, which those children…. Because they know the girls should abstain which according to them most of them are not in a position to abstain"*
> ***(KWL_ME_KII(HT)_EW.docx)***

Male Involvement in GBV and SRHR

Participants in Narok said that some boys and men were involved in GBV prevention and promotion of SRHR in order to protect women and girls. When women and girls were victims of violence, the participants said that other males assisted them in seeking justice. In Kwale, the major causes of violence and possible solutions were discussed between cultural elders and men through a forum known as the *"baba clinic."* And in West Pokot, boys organized clubs in schools to learn about issues around GBV and to help safeguard vulnerable female students. Men in Garissa, however, were only involved only when there was domestic violence.

> *"R: Men have been involved though not in large numbers. For the few who have volunteered to want to see justice to the girl, have been at the forefront."*
> ***NRK_ME_KII(CBO1)_AP.docx***

> *"R: Yes like us, the cultural leaders or Sauti ya wanawake we have baba clinic. In baba clinic, we invite the men only and we discuss, we also call it Sema clinic where men are educated, we discuss and men say what they have, so we get the challenges and solutions there, they give their way forward and then we call the women and tell them*

that the men said that you are like this and this, is it true? They also open up and say what they have. So we look for those challenges and have meetings with the youths and tell them your parents; father and mother, said that you are the source of this and that, is it true? So the youths also say what they have. So all these challenges are consolidated and then we put the three groups together we make one convection where they can all give their views and get the conclusion of those issues. So we normally do that." ***KWL_ME_KII(CL) _EW.docx***

"R: I can say that men in this community have accepted to join the community groups and help in creating awareness like they are supporting what others are doing by fighting against gender-based violence. To be boys like I said I am a teacher, in the school, these boys come up and form a club where they take part in teaching others about rights and participating in gender equality by supporting the girls if there is something that has happened to them". ***WP_ME_KII(Teacher1)_JK.doc***

Changes in SRH and GBV Response: *What has worked well*

Community Perspective West Pokot

The FGDs findings show that there were some changes in perception towards SRHR. For instance, trends in contraceptive use among men and women of reproductive age were noticeable and reported to have changed over the last 12 months in West Pokot. FGD participants reported that there was an increase in the uptake of contraceptives among the men and women in West Pokot as indicated by the data from the hospitals that shows an increase in the number of women seeking family planning services and the zeal shown by the men who openly asked for a refill of condoms. These positive attributes have seen more people in the community become aware and knowledgeable about contraceptive use.

"R: I can say that there has been a change in the uptake of family planning because men are asking for more Condoms when you pass nearby they will tell you their condoms are depleted bring us tomorrow's boxes of condoms so you see that means I have given information, they accepted the information now they want the commodities." ***(WP-CBO-FGD)***

*"R: Also I can say there have been changes In the data we collect because it shows there has been an increase in the Uptake of contraception because we always do the in-reach activities. So it means the number of the community members who are taking family planning has increased and the champions have played the roles well in advocating the needs of the community by convincing them to go and take the family planning****." (WP-CBO-FGD)***

Further, evidence from the group discussion indicates that the youth and women have been empowered on the issues of SRHR and GBV. Women are more aware and have taken self-initiative during their weekly meetings (chamas) to educate themselves on sexual reproductive health. Similarly, the youths have also formed self-help groups to champion and advocate for their SRH rights.

"R: I Can say through these activities which we always conduct in the communities, I personally have been focusing on the youth and adolescents and mostly women. I can say that when these women always meet like in my community the women have this Sunday chamas meeting where they usually meet, it reached a point where I was having a session with them and they told me that they wanted a copy of what I usually teach so I went and printed and give it to them. So they usually use these copies to empower themselves." ***(WP-CBO-FGD)***

"R: Of course, there has been changes in youth and women empowerment there has been self-help group that has come in place in terms of youth for Youth where they take part in advocating their rights some of those self-help group are coming from among the champions who are taking part in this accelerate program so it means we have given women a platform to empower themselves" ***(WP-CBO-FGD)***

Changes among Duty Bearers (Community Leaders)

The participants stated that they have started to engage and collaborate with the community leaders and institutions like the police department and the department of children protection. They gave examples of instances where they have been invited to be part of major events and functions targeting adolescents in the county. The police department has also picked up on the issue of GBV by creating a help desk where the community can report cases of gender-based violence.

"R: I think some of the changes like right now at least the police department has a desk where someone can report cases of gender-based violence so it means there is positivity they are taking up in making sure that this violence is eradicated in the community" ***(WP-CBO-FGD)***

"R: To add to what he has said there is a department that is called the children protection unit it's a building on its own where it handles matters to deal with child violations anything to do with children and it is a privilege because whenever we have any child functions or International day of children we normally get invitations to attend so it shows that we have an impact as we, the youth champions" ***(WP-CBO-FGD)***

Further, the participants mentioned that unlike previously where cases of GBV were handled locally i.e. through the 'kangaroo courts, the community has embraced accessing justice for the GBV survivors through the legal systems. Currently, cases of GBV are reported to legal authorities like the police and health services sought from the hospitals by the survivors.

"R: I think there are changes in the justice system because most of the cases were ending up at the kangaroo courts before the program was implemented. But now we have seen increased cases being reported to the legal authorities such as the police areas and the hospital for rape cases. So I think the way it was before where matters were just being done and ended at the kangaroo level where there was an injustice to the female gender. But nowadays you can go to legal authorities that are available now and get information than how it was before the kangaroo courts." ***(WP-CBO-FGD)***

Changes in the health facility and referral pathways

Access and linkage to SRH services were said to have improved in the last 12 months. This is evidenced by the participants' indication that the community members can easily access contraceptives like condoms even from the CBOs unlike previously when they had to visit the health facilities.

> *"R: I can say there have been challenges because before we didn't get contraceptives Materials like condoms but because of coordination between the CBO and the headquarters We are able to get free Condoms and we teach the community. The community members sometimes come to find us so we give them condoms, unlike the way it was before when the health facilities only used to link the community. So it means there are changes because they cooperate with us In giving contraceptives to the community such as condoms."* ***(WP-CBO-FGD)***

Changes from the local Structure Perspective Garissa and Narok

Community Perspective

The FGDs findings show that there were changes in perception towards SRHR and GBV in Garissa county over the last 12 months. The FGD participants reported that there was an increase in the uptake of contraceptives among women in Garissa. Similarly, women have become more open to talking about access to services and reporting on issues of gender based violence.

> *"R: The issues of early marriages, family planning because even some community members are coming to our place asking how they can get assistance in the relevant departments." (Garissa-CBO-FGD)*

> *"R: Also there is the acceptance of women to come out openly to report cases about gender violence." (Garissa-CBO-FGD)*

Similarly, in Narok county, the FGD participants reported that there was an increase in the uptake of contraceptives among women. Also, men reported that their partners and other women have become community champions advocating for contraceptive use among other community members including fellow women within the community. The youths have embraced the use of condoms to prevent early pregnancies. These positive changes are attributed to the community outreach activities that have seen more people in the community become more aware and knowledgeable about contraceptive use.

> *"R: We have also made youths aware on the need of condoms to protect themselves from diseases and also provide protection from pregnancies. The men are now using condoms as a method of family planning." (Narok-CBO-FGD)*

> *"R: The thing I have seen happening in the community, is there are times we bring together the men and women and sensitize them on the issue of family planning. I have seen the*

males have been embracing the use of family planning they even call and ask you when you are taking her for Family planning so now they are aware. So on the issue of GBV, I have seen a tremendous decline in my community due to sensitization." (Narok-CHV-FGD)

"R: We have also made the male youths aware of the need for condoms to protect themselves from diseases and also provide protection from pregnancies. The men are now using condoms as a method of family planning." (Narok-CBO-FGD)

Change in Duty Bearers (Community Leaders)

The participants mentioned that the community including chiefs and sheikhs have become more involved with SRHR and GBV at the community level. They refer patients as well as survivors of GBV for help in the right offices. The survivors of gender-based violence have successfully sought justice and their perpetrators have been brought to the book.

"R: We tend to get more calls from chiefs, you know those who are the administrative side in those areas and they tend to like refer to us patients; those people who have those issues and they talk to us about it and if they need any help from our side, they tend to call us and we go to do those sessions in those areas." ***(Garissa-CBO-FGD)***

"R: And there were a lot of cases that were reported and justice was served. Those who…the perpetrators," ***(Garissa-CBO-FGD***

Through the training given to the local leaders in Narok county, they have become more involved in championing SRHR and campaigning against gender-based violence. The chiefs have taken up the task of ensuring that teenage pregnancies reduce in the county. Similarly, women have become aware of the actions to take in cases of GBV. They now understand that they can report such cases to the police even when the perpetrator is their partner.

"R: Another thing within the community the women have known is that when a man beats her she understands that she doesn't have to just sit there, so when a man threatens her she tells her there is a law that protects her. And in the community, we usually fear issues regarding to the police, at least that one has reduced GBV cases. We also have seen the hotline numbers that are being provided like one for the ministry of gender and police numbers tool so she can easily pick a phone and dial to report a case that is happening on and get rescue mechanism." ***(Narok-CBO-FGD)***

"R: It has helped to build trust between us and the duty bearer like the chief, since PS Kenya is a known organization it has to ease the penetration on the community. The chiefs from Narok North and Transmara West have received training on the program and know PS Kenya. So now when we want to reach the community on SRH and FGM it is now easy." ***(Narok-CBO-FGD)***

Changes in the health facility and referral pathways

Access to SRH and GBV services has improved in Narok county over the last 12 months. The FGD findings show that the community members have been sensitized on the availability of contraceptives and GBV services in the local facilities. In cases where referrals need to be made, there are established linkage systems in place to help the patients and survivors get the help they need. Hotline numbers have also been availed for the community members to call at their convenience.

> *"R: Yeah, where we are in the rural areas when we sent the patient to the hospital he gets the services, maybe it was an emergency and you didn't have time to accompany them to the facility, so immediately you write the referral to the patient will get first priority on the queue. He/she gets faster services and the doctor may contact you."* ***(Narok-CHV-FGD)***

> *"R: Another thing within the community the women have known is that when a man beats her she understands that she doesn't have to just sit there, so when a man threatens her she tells her there is a law that protects her. And in the community, we usually fear issues regarding to the police, at least that one has reduced GBV cases. We also have seen the hotline numbers that are being provided like one for the ministry of gender and police numbers tool so she can easily pick a phone and dial to report a case that is happening on and get rescue mechanism."* ***(Narok-CBO-FGD)***

> *"R: There are dispensaries and hospitals in the villages when they get a case that they cannot handle, they refer to the main referral hospital and the treatment that they receive at the facility health providers is satisfactory. So the linkage has really improved."* ***(Narok-CBO-FGD)***

Instances of GBV, such as early marriages have decreased, according to the participants who were interviewed. Community members' perceptions and attitudes about educating females were reported to have changed and they began providing them with educational opportunities. The response to GBV was also reported to have improved. The CHVs were crucial in ensuring that abused women and girls received medical attention, for instance.

> *"R: The situation is better because of education which we have been sensitization the community as the members of the CBO even now we do sensitize people. Village elders also do sensitize the community. So these sensitizations I can say have reduced and if these sensitizations can be improved and continued, I think these cases of GBV will be over"* ***(KWL_ME_KII(CBO)_EW.docx)***

> *"R: Another change is the community has started educating girls unlike in the past when only boys got the privilege to study. The community has started noticing the efforts of educating the girl child. This is because most NGOs in the community, have been trying to empower the girl through education".* ***(NRK_ME_KII(AC)_AP.docx)***

> *"R: In terms of medication, medical has improved because it starts in the community with the CHVs who collect the community information and take them to the health facilities, they also take patients from the community and take them to the hospitals. For*

*example, if someone has been raped, then the CHV is the first contact taking that person to the relevant place not referring but accompanying them. So that one has helped a lot even then community knows that in case this thing happens, they will go to the CHV, if this something happens"(**KWL_ME_KII(CBO)_EW.docx)***

What has not worked well.

However, GBV survivors still encounter obstacles while accessing services. For instance, one needs financial resources to access the legal system, and there is a shortage of necessary medications in hospitals.

*"R: For justice, you need to have money. To get a lawyer you need money, police you have to give them a bribe and if you don't have money where is the justice? You will go to Kwale courts and in the end, nothing happens. The response is there but it depends on your own response in terms of following up the case because for the police to follow up your case you need to have money". (**KWL_ME_KII(CL) _EW.docx)***

*"R: You know in terms of medical you know most of the hospital they do not have medicine you will be taken to hospital then the doctor will give some painkillers then she will walk home" (**GSA-ME-KII(Teacher2)-AO.docx)***

Findings from Health Facility IDIs Kwale and West Pokot

Service delivery SRHR and GBV

Healthcare providers in Kwale county stated that cases of gender-based violence can be addressed by ensuring the health facilities offer screening services for GBV and SRH, conducting medical and laboratory examinations, treatment and provision of psychosocial counselling. For complicated cases, referrals to higher-level facilities was recommended. The facilities also lso help with the investigation and reporting to the police as well as attending court sessions as expert witnesses.

*"R: Once we get a client, GBV, we have our leader who takes care of. He is a clinician, and we have to handle over the patient to the clinician who takes the client through like the medical examination, taking of the history and then documenting the case history and sends the patient to the relevant institutions like maybe the police or if the maybe client needs referral to a higher hospital, so the clinician does that." **(Kwale Nurse 51)***

*"R: I represent the patients in the courts as the professional witness, so I fill in the P3 form, I treat them also." **(Kwale Clinician 35)***

"R: My role in gender-based violence is to screen patients who have undergone gender-based violence and in case we get the patient we also do counselling and managing maybe giving treatment if it is a rape …in case it is a rape giving treatment, sending, referring clients maybe if the patient needs service which is not here, we refer the clients also to the

place where they can get the services. So the overall is screening and assisting those patients to get the right services." ***(Kwale Clinician 32)***

Similarly, in West Pokot, the healthcare providers mentioned GBV services provided to include medical and laboratory examinations, psychosocial support through counselling and patient referrals depending on the case. In cases of rape, the facilities offer HIV testing, pre-exposure prophylaxis (PEP) and contraceptives to the survivors of GBV.

"R: And for gender-based violence patients, as the initial contact for these patients, while we have them, we offer the initial medical treatment and examination and patient referral to the necessary authorities depending on the case." ***(WP Clinician 25)***

"R: Psychosocial support, number two we do HIV testing, and, uh, we provide Prophylaxis treatment for STIs, uh, we also provide emergency contraceptives for teenagers, and also, we provide, uhm, TT, and, aah, referral systems that require linkages." ***(WP Clinician 43)***

However, there are facilities in West Pokot that do not offer GBV services. Such facilities lack trained personnel and expertise to handle such cases. Additionally, they do not have the medical supplies and equipment to report cases of gender-based violence.

"The reason is one, we have not yet been given training, also issued with the required tools and equipment, for reporting on gender-based violence." ***(WP Nurse 37)***

Family planning services

In Kwale county, the healthcare providers indicated that they provide both long-term and short-term contraceptive methods. The long-term methods provided include implants and IUD insertions while the short-term methods included injections, depo, emergency pills and condoms. Generally, IUD insertions require examination to ensure that clients are free from infections.

"R: We offer both long-term methods of family planning that's the insertion of implants, IUCDs and also offer the short-term methods like the injection, depo (Provera), and the pills and also we counsel on the natural family planning methods and also to some offer condoms to those who are not eligible to hormonal contraceptives or they have a contraindication to some of these family planning methods." ***(Kwale Nurse 50)***

"R: We have the injections, which is the depo Provera and then we have the implants either the Norplant or the jadelle and we also have the COCs the contraceptives pills for the progesterone and also the IUCD which we don't usually insert unless we are very sure that the client is clear of any infections and then we do insert the IUCDs." ***(Kwale Nurse 51)***

Youths and adolescents have a variety of preferences regarding the methods of family planning. While some prefer implants, others prefer emergency contraceptives or condoms whereas some have a liking for depo. However, the providers indicated that they always counsel and advise adolescents to use long-term methods like implants or depo. This is because of the contraindication of emergency contraceptives which should only be used twice a year.

> *"R: The youths mostly, prefer implants, the long method of family planning and condoms and to some, they prefer to be given emergency contraceptive pills but we counsel them on that method because you know you cannot give it twice a year. So we counsel them on the risks of using the emergency contraceptive method of family planning. Even if also these are sexually active adolescents it means that when you give them the emergency contraceptives, there is also a likelihood …because they are sexually active, they will still indulge in sexual activities meaning that you will have to offer the emergency contraceptive and of which I said, it is contraindicated to be given for more than twice a year. So we counsel them on the long method of family planning also because some of them are school-going children when they are in school maybe they will not get the opportunity to come back for their TCAs that's the return visits so we counsel them on long-term family planning methods and of course some do accept others, prefer the depo contraceptive because they tell you we are only going to be there for 3 months and you know that the duration of depo Provera is three months, yes the return date is after three months. So most of them also prefer Depo because you just get a jab you go then after three months again you come"* ***(Kwale Nurse 50)***

On the other hand, older women prefer long-term methods; more specifically implants like Implanon and Norplant. Other women prefer using depo. Choice of long-term methods is mainly attributed to the number of children these women have and the desire to delay pregnancy.

> *"R: The older women, most of them go for implants, yes the Implanon, the Norplant. In this community, they don't like coils, yes. they prefer the Implanon because if you see these old women they have many children so they prefer this one because they want to prolong the pregnancy period. They don't want to deliver soon."* ***(Kwale Clinician 39)***

Generally, there is an overall preference for depo for both older women and adolescents in Kwale county. This is because of the convenience and confidentiality it confers to users.

> *"R: One is the culture about it, we call woman's choice within Kwale. They like it because once they get the injection no one will know, the husbands will not know, and children in school won't know that they are already under the method. Again, it is a three months period so at least once the adolescent closes schools they come for it or the mothers… the adults. So it is easier for them. They don't like the pill burden of taking the medication because they forget, yes."* ***(Kwale Nurse 50)***

In West Pokot, both short-term and long-term contraceptive methods are provided as per the national guidelines. However, some participants mentioned that they do not offer contraceptive methods that involve surgical procedures like BTL and vasectomy.

> *"R: We have the hormonal and non-hormonal, with the short-acting and long-acting. The only ones that we do not have at the moment are the surgical ones which are the BTL and vasectomy but all the rest I think we have."* ***(WP Clinician 25)***

Most of the youths and adolescents in West Pokot prefer injectables and implants. In general, Depo is their most preferred method because the secrecy and longevity it provides users. However, some adolescents opt for condoms because its accessible and affordable. Non use of implants is attributed to fear of failure of the method.

> *"R: The most preferred are the injectable and implants, both for three and five years."* ***(WP Clinician 43)***

> *"R: But some of them fear. You know that fear the knowledge that maybe if the use the implant they will not be able to conceive."* ***(WP Clinician 32)***

Similarly, older women in West Pokot prefer injectables and implants. Most women use the methods without the knowledge of their partners/husband hence their preference for these methods.

> *"R: Injection (Depo), Pills: COCs, POPs, Implants, IUC and Condoms. Depo is the most preferred by both the youths and older women because it can be used secretly because most of their husbands/partners don't want them to use FP."* ***(WP Nurse 39)***

Post-abortion services

The facilities in Kwale county provide post-abortion services including Neurological Vital signs (NVS) and treatment for those who have had an abortion. In most cases, post-abortion clients are referrals from lower level facilities such as clinics or the gynecological wards.

> *"R: Yes, we also do offer post-abortion services though we get a few cases, we get a few cases unless I don't know why they don't come but we advocate for them to come especially within two weeks they have to get services unless they are referred you know they will not come here to tell you that they had an abortion. Usually, the ones who come, the few who come are usually referrals maybe from the gynaecological ward maybe from the clinics that is when they come."* ***(Kwale Nurse 50)***

> *"R: We also offer post-abortion services, yeah we do NVS (Neurological vital signs) and treatment of the post-abortion survivors."* ***(Kwale Clinician 35)***

Similarly, in West Pokot, the participants agreed that they offer post-abortion services. However, they did not provide details of the specific services offered.

"R: Yes, we do." ***(WP Nurse 39)***

"R: Yes, we do treat them" ***(WP Nurse 37)***

Circumstances of unacceptable use of FP

Responses from healthcare providers in Kwale county show that most women, especially married women use family planning without the approval of their partners. This is viewed as disrespectful and against community values. The community also views use of contraceptives among adolescents as encouraging sexual activity. Similarly, for married women, the use of contraceptives is considered a sign of prostitution.

"R: They are viewed as if they have gone against the community values and they don't respect their husbands and they also view like it is as if they are prostitutes because they are saying why are you doing family planning and yet you are married, you have a husband? So you are doing family planning because you are going out of the marriage maybe you have several partners so you want to protect." ***(Kwale Clinician 39)***

"R: Okay, they say in the community, we are encouraging the girls to practice more sex and you know with their religion especially I stress on the religion because a young girl is not supposed to, when we offer these family planning services like we are encouraging them to practice sexual activities so they wonder when they say a young adult they start questing why is this girl here…you know such things." ***(Kwale Nurse 50)***

There are existing myths and misconceptions about the use of contraceptives and their side effects. Some members of the community believe that the use of family planning may result in infertility, bleeding and reduced sexual pleasure. Some also believe that implants may cause harm to their partners during intercourse. Religion is also a barrier to contraceptive use.

"R: Yeah, there are so many reasons. It is just I think it is their beliefs. Someone believes that when I use family planning I can't get a baby again, others believe that when you use family planning you will never be sweet with your husband (laughs) another person believes that when you use family planning you will bleed, you will be bleeding on and off. Another one also says when you use family planning like the coil- you see the coil, when your husband goes in you will be punctured or pierced by that device, yes." ***(Kwale Clinician 39)***

"R:Yes, we have resistance from men. Some men think of a lot of myths and misconceptions about family planning. Some, most of the women are saying that their husbands are not supportive because they think that during sexual intercourse with them, they are viewed…it is not that sweet when they have the method than a case whereby they don't have the method. So most men prefer a woman who has no family planning method. So most men don't support their wives to take family planning. The other issue is religious issues. Most of them are saying that God created men and women and then told them to fill the world. So, most of them, they are issues like religion and then about

the…another thing is the …they think that family planning can make a woman to not to get the children." ***(Kwale Clinician 32)***

Similar perceptions were shared by healthcare providers in West Pokot. Men do not approve of the use of family planning by women and adolescents. It was alleged that women encourage adolescents to seek family planning services at the facilities. Community norms and perceptions, side effects, myths and misconceptions as well as religious beliefs still act as hindrances to the use of family planning. Religious affiliations such as the catholic and '*Dini ya msamba*' a local religious group, discourage the use of contraceptives. More so, women using contraceptives are perceived to be promiscuous and are promoting prostitution.

"R: In this community, seeking family planning services, it seems like, uhm, women do not have a right, it is a secret, so it against their right, it is like their rights are violated when they are denied reproductive health services, either by their spouses, because even in this facility, when a spouse discovers that a woman has gone for family planning, they come and intimidate even the doctors." ***(WP Clinician 43)***

"R: Yes, they always say that women who embrace family planning will bleed terribly, continuously bleeding, and then, others talk about the issue of being a prostitute. And then others say, family planning will make women not to conceive." ***(WP Nurse 37)***

Reasons for low contraceptive uptake

Barriers to contraceptive use among adolescents in Kwale county were cited by the healthcare workers. Noticeable among them were the low levels of education in the community, the negative perceptions on the use of contraceptives, the lack of awareness and limited information on FP, adolescents' inability to consent and lack of youth-friendly services/infrastructure at the facilities.

"R: The consent issue is because the lady at the family planning will not be free to give family planning if she thinks that this can have problems in future. She cannot even say it to the people, to the teenagers unless they come for it or even if they come for it, without a valid reason or maybe she is already pregnant or she has delivered now mamake anamleta apate (her mother brings her for) family planning those are the only children I have seen getting family planning but the teenagers that have never been pregnant I doubt, I have not seen them." ***(Kwale Clinician 35)***

"R: Another thing also is lack of knowledge because education level in this place is very low. So people don't have enough knowledge about what is happening, yes." ***(Kwale Clinician 39)***

"R: Also I think as I said, in our facility, we don't have a place where the youths need you to know I said because of the challenges of space, staff, the infrastructure here I think is not youth friendly to me, is not youth-friendly at all." ***(Kwale Nurse 50)***

The barriers were similar in West Pokot. The providers noted that most of the adolescents use FP in secrecy and do not openly visit the facilities. There are also issues of the knowledge gap on FP use and the negative perceptions of the community members on FP. The providers also attributed the low uptake to the fact that most of the adolescents are in school and therefore they do not visit the facilities for contraceptive services.

> *"R: Okay, the reason is that one, these young ladies, lack information, two, they are also very shy to come to the facility and ask for such services, because, let's say a young girl of 15 comes to the facility for such services, she will think that the health worker might think that she is sexually active. So, I think, if they are empowered and given information, the issues of early pregnancies might really reduce"* ***(WP Nurse 37)***

> *"R: I think number one, it is because currently it is a school-going period and of late we really have few of them conceiving around that period. Most of the patients who come for family planning have either conceived first or more times."* ***(WP Clinician 25)***

> *"R: There is a low contraceptive services uptake among this group and that is why some of them come to the facility when they are pregnant. This is because of the misconception that FP causes infertility, lack of knowledge about the FP services offered in the facilities and some of them fear coming for the FP services because they may bump into their parents who are also coming for the FP services."* ***(WP Nurse 39)***

Violence against Women

Physical and sexual violence are the most common types of violence in Kwale County. Sexual violence is most rampant among adolescents and young girls who are either raped or forced into engaging in sexual activities against their will by their parents in exchange for money or material gifts from the perpetrators. Physical violence is most common among married partners; either intimate partner violence by the men or women.

> *"R: Okay, like as I said, you know when a youth comes when you ask them you know we have to know why they have come, most of them tell me that sometimes they are forced to indulge in sexual activities from their parents. Yeah they tell you that the parents always ask them you are here when your friends are looking for money and you, you are just here, what are we going to eat? So when you tell her a youth like that it is direct suggesting that you should go. How can a youth look for money? So they get boyfriends and they will just indulge themselves in sexual activities and a few comes with rape cases, just a few, rape cases, and other coercion from their partners."* ***(Kwale Nurse 50)***

> *"R: These ones happen mostly at home, especially the physical violence; those ones happen at home where the husband beats the wife or the wife is being physically assaulted by the husband and also vice versa, But these other sexual violence among the young girls that one happens when they are coming from maybe Mandrassa or from harusi (weddings) you know these night weddings, those ones happens a lot especially when there is those weddings. You know these people like doing these at night, yeah ngoma,*

ngoma, ngoma (music, music, music), night discos so that is where sexual violence is coming from." ***(Kwale Clinician 39)***

Women who are survivors of violence rarely take any action or report these cases of violence. For adolescents, they report the incidents to their parents. Cases of violence emerge during the post-pregnancy visits at the health facilities or during family planning visits. Most of the cases are settled within the local context with the involvement of village elders. The key driver of intimate partner violence religion which expects women to be submissive.

"R: When they are exposed to gender-based violence, most women persevere. They persevere and …until it is too late that's when they seek care. You know according to this side because of religion and the religion says that women should be submissive. So they think that a man can correct her woman and it is acceptable in the community to beat a woman because she is a wife so she needs to be controlled by the man. So it is not something new because of the religious factor that a woman must be submissive. So in case a woman is beaten, so it is because she has decided not to be submissive. So a lot of people don't think that it is a unique thing. So in case it is too much now maybe the woman is beaten to an extent that maybe she can be admitted at the facility that's when they open up, yes." ***(Kwale Clinician 32)***

"R: Most of them run to the parents or wazee wa mtaa, (village elders) or the chief. Some who are enlightened come to the hospital or go to the police but in most cases they go to the village chairman. Those who may be the young ones because they don't want to say it, they just cool it down until you realize there is a pregnancy that's when the parent can take action now. When they go to the village chairman, they force the child to say who the pregnancy is. If they say they call that person they do it underwater. It is just like that. That's why you see a lot of teenage pregnancy here in Msambweni. There is what we call Kangaroo courts; they solve underground, they don't bring to the hospital or the police." ***(Kwale Clinician 39)***

In West Pokot, the most common types of violence are physical and emotional violence. There are also cases of sexual violence like rape though they are not as rampant. The issues of violence are mostly driven by drug and alcohol use. Cases of FGM and early marriages are also being reported in the county.

"R: Yes, women can never come here and say they were beaten by their husbands, they will just talk of other things, like maybe they fell down" ***(WP Nurse 37)***

"R: Sexual assault is there, but people don't know when to seek for care, and, ah, whether it is their right, they stay in denial, with their problems, then there is the issue of ah, early pregnancies, early marriages" ***(WP Clinician 43)***

"R: Assault is the most common. Rape is rare. Most assault cases happen in their homes." ***(WP Nurse 39)***

There are divergent measures taken by the women and adolescent girls of West Pokot when incidents of violence occur. Some women remain silent in the wake of violence and only report when the situation gets out of hand. However, enlightened women, always seek justice either locally through the village elders or via the legal system by reporting to the police. A few of the women seek medical attention as a first resort.

> *"R: A few who are enlightened, are the ones who will start by seeking medical care. But the majority would want to seek justice first. Because, if you see, eeh, see, uh, the data that is collected from the facility, it is fewer compared with those who go to report to the gender-based violence desk at the police stations, or the cases that are reported to the chiefs."* ***(WP Clinician 43)***

> *"R: It is not usually after the first case. It is either these times the emotional and psychological abuse has been going on for a while or it has now gotten to physical abuse but it is the physical abuse that is so severe that it needs medical attention."* ***(WP Clinician 25)***

> *"R: Okay, the first thing they do, although they don't reveal that their husbands beat them up, and then you ask them, then who did it? Then they point to other people, and now, when you tell them it should be a police case, they will start feeling uneasy, and that is when you will know that that thing is originating from home."* ***(WP Nurse 37)***

Integration of GBV services in routine SRH

As evidenced by the responses from the health care providers, integration of GBV services into routine SRH is feasible strategy in Kwale county. For some facilities, integration of services is an ongoing practice where SRH services are concurrently provided with GBV-related services.

> *"R: If a woman comes for example, for family planning and then we screen, if that woman is a victim of GBV and is in the family planning room so we can counsel the woman there and advise her if in case he needs to follow up to get her rights in the courts. So in that room, she can get family planning and GBV, GBV counselling in case it is a rape she can get P2 there, she can be referred to the lab and then she comes back to that room and get the other services like being offered P2, can be given counselling, PEP there and then we have CCC here. So in the CCC, we also do counselling for GBV and then all the other services are there, yes.."* ***(Kwale Clinician 35)***

> *"R: it is practical. It is in place. There are not in the same room, they are in different rooms but the services are on and running."* ***(Kwale Nurse 51)***

While the facilities are open to embracing integration, there are underlying challenges that hinder integration of services. Some of the challenges mentioned by healthcare providers included inadequate staffing, lack of appropriate infrastructure, inadequate space, and inadequate skills to handle such cases. There are also issues of stigma arising from the community as well to contend with.

> *"R: that's a real pressure. Nobody has been trained on GBV in our facility. WE are just trying to work with what we were trained from college (inaudible 18:31:54) package ya (of) GBV now on consultant on GBV no."* ***(Kwale Clinician 35)***

Similarly, in West Pokot, integration of GBV services into routine SRH was accepted. Although only a few facilities have integrated services for GBV and SRH.

> *"R: Integration of GBV and SRH services is feasible/practical in the facility context. GBV and SRH clients are both attended to at the OPD."* ***(WP Nurse 39)***

> *"R: Okay, in gender-based violence, our facility like maybe in this room has been kept aside for GBV. That is number one. So, we have a room, they provide us with those tools for assessment or screening. Number 2, we have made it free of charge. It is a walk-in-walk-out."* ***(WP Clinician 32)***

Some of the challenges mentioned by the healthcare providers in West Pokot included inadequate staffing, a Knowledge gap to handle such cases and supply stock outs.

> *"R: Lack of commodities, for example, urine strips, sometimes VRDL isn't available, most staff aren't trained, lack of reporting tools like PRC forms, there are also a few challenges associated with referral of clients because they have to use their own means because there is no ambulance; cost is also a challenge"* ***(WP Nurse 39)***

> *"R: One is the knowledge gap, we need training, number two we need the tools, for the PeP, initially we used to stock here, for PMCT mothers, and emergencies, but off-late we have not had such provisions, so all the cases we have to refer. If we get support from the MOH and supplies, then it would not be hard to integrate the services."* ***(WP Clinician 43)***

> *"R: No, I don't have the capacity. The issue of staffing, I am just alone here, to run all such services it will be a herculean task for me."* ***(WP Nurse 37)***

To address the challenges of integration of services, healthcare providers from both Kwale and West Pokot concurred that a key area for improvement was capacity building for the staff. The providers felt that this would empower the providers to gain confidence in handling issues of GBV. There were also suggestions for increasing staff and equipment supply to the facilities.

> *"R: Integration efforts of course, first of all , is continuous trainings to staff, more health care workers should be sensitized and trained on GBV and how to tackle a victim and another thing is the tools should be available and then for the county government staffing. Yeah more staffs should be deployed to the facilities so that we can have ample time with them and at the sometime not hindering other services because once you have a victim here …that's means if you have a person who has come and want to access family planning*

has to wait for me to finish to this patient or another person if he comes here because he wants …he is sick he will wait for me, yes. So those three things." ***(Kwale Clinician 32)***

"R: Sensitizing the staff about GBV and how to handle them, community mobilized and be made aware of the GBV services offered in the facility this will help do aware with the stigma, the staff who haven't been trained on GBV/SRH and retrain and or update the staff who have been trained because things change and also provide GBV reporting forms" ***(WP Nurse 39)***

Findings from Facility IDIs Narok and Garissa

Service delivery on GBV

In Garissa county, most survivors do not seek GBV services at the local facilities but instead visit the county referral hospital where the services are offered. The survivors are often linked to the facilities through the CHVs thereupon lab tests are done and medication is provided. The facilities also provide psychosocial support through counselling and in the case of major complications, the survivors are referred to the county hospital.

"R: Clients are not coming for the services so they go to the main hospital for those services" ***(Garissa Nurse 45)***

"R: But for now we do not have any GBV services we have never witnessed a client." ***(Garissa Nurse 25)***

"R: No turn over clients are not there but in case there are there we offered them we haven't turn any clients who come for that services" ***(Garissa Nurse 45)***

"R: We offer diagnosis, management of minor elements and referral services." ***(Garissa Nurse 38)***

The healthcare providers in Narok county noted that health facilities respond to GBV cases by offering GBV screening services, medical and laboratory examinations, treatment and providing psychosocial counselling. However, some of the providers indicated although they offer counselling services to GBV survivors, most of them have not been trained in counselling. Other facilities lack laboratory services to offer conclusive examination to the patients hence they make referrals to other facilities. In the case of medication, the facilities only do the prescription of the drugs to the patients who then have to purchase the drugs elsewhere. In the instance that it is a rape case, the facilities offer HIV testing and pre-exposure prophylaxis (PEP) to the survivor.

"R: For now, we don't have the lab services here, if it is lab here we just do like a physical examination let's say, cos we don't have lab services for the client, maybe PITC and what, only, because the sperm… is done in Narok." ***(Narok Nurse 30)***

"R: We provide treatment, we offer emergency pills, combined estrogens progesterone oral contraceptive pills (COCs), although the patients usually go and buy we prescribe, we have laboratory services, like urinalysis, testing for sexually transmitted infections vaginal swabs, post-exposure prophylaxis, especially for rape cases, and we also refer for psychological services." ***(Narok Nurse 45)***

"R: When a survivor of a rape case comes in, we attend to them, we attend them as an outpatient, and since we don't have most of the medicines here, we mostly request the survivor to buy after transcription given by the doctor. You can see we have no room for special cases here and we don't send them away, we actually attend them with the ones we have as they get what's needed." ***(Narok Nurse 28)***

Family planning services

In Garissa county, the healthcare providers indicated that they provide both long-term and short-term contraceptive methods. The long-term methods provided include implants and IUD insertions while the short-term methods included injections, depo, emergency pills and condoms.

"R: We offer short-term methods, that one includes injections, emergency contraceptives. We also offer a long-term reversible contraceptive method that is implants and IUCD." ***(Garissa Nurse 38)***

"R: The mostly provided here we have the implant and Jadelle and the emergency pills those are mostly used in this facility" ***(Garissa Nurse 25)***

"R: We normally have condom normally accessible to the youth for those who want it normally slides somewhere there and in the pharmacy we have a condom box where its access to the youth or anybody who want it." ***(Garissa Nurse 45)***

Both women and young girls have a preference for implants and injectables like depo. Their preference is informed by their secret use of contraceptives. Most women do not want their partners to know of their contraceptive use and hence feel injectables and implants offer the needed privacy and confidentiality. Similarly, oral contraceptives come with the risk of forgetting to use them. There are also misconceptions about the possible side effects of using IUCDs.

"R: ok in here MCH at sub-county hospital family planning, the most common is Depo which is injectable, jedella insertion and oral pills but most of the mothers prefer injectables Depo they normally said that it does not give them a lot of disturbance while swallowing pills might forget so whenever they take Depo its continues method to them" ***(Garissa Nurse 27)***

"R: Mostly they use the implants and the injectable. Eeh you know sometimes they say that they have that misconception of saying the IUCD is a risk to cancer. Like their husbands are against using them so they prefer using the injectable and the implants" ***(Garissa Nurse 25)***

Similarly, in Narok county, the providers indicated that the facilities offer both long-term and short-term family planning methods. The long-term methods provided include implants and IUD insertions while the short-term methods included injections, depo, emergency pills and condoms. However, they are majorly faced with commodity stockouts for condoms, implants and jadelle.

> *"R: It is so hard to say routinely because they have been out of stock for quite a while. Like right now we only have COCs, but initially, we had Depo Provera, we had the implants the ones for 3 years and 5 years, we used to have the COCs again, even condoms have been out of stock for quite some time, they have just been brought recently. What else, the IUCD are here"* ***(Narok Nurse 30)***

> *"R: Okay, we have all the commodities and services. We offer them. We have the depo Provera injection. We have combined oral contraceptives. We have progesterone-only pills. Contraceptives. The 3 years and the 5 years. And we have IUCD. Yes. And we offer all the family planning services."* ***(Narok Clinician 30)***

The women and adolescent girls in Narok have varied preferences regarding contraceptives. Some youths prefer short-term methods, especially the young adolescents who have not given birth while those that have given birth prefer long-term methods like the implants that go for three five years. Preference for long-term methods is a precaution against getting another pregnancy. However, older women, prefer long-term contraceptive methods. This allows them to space their next pregnancy as well as to keep their contraceptive use a secret from their partners

> *"R: For the youths, they prefer short-term service, for the older women they prefer longer, that's for spacing their children, and also for others, they prefer injection especially when their partners are against the family planning and hence not able to realize."* ***(Narok Nurse 45)***

> *"R: For the youths, they prefer short-term methods, and older women prefer a long time. Also, Its too many misconceptions about this group. When you want to offer someone an IUCD, they give different misconceptions. And another factor that is affecting them I think is the male, when they put Jadelle or different methods, the next day they tell them to go and remove. So they prefer depo because they just come and inject and they go, and this male cannot recognize it."* ***(Narok Nurse 28)***

> *"R: The Adolescents mainly normally come for the long term, especially for the ones who have given birth. You find them coming for the 3 years and the 5-year one. And the Adolescents who have not given birth, they normally come for the short term, especially the Injection one."* ***(Narok Clinician 30)***

Post abortion services

Healthcare providers in Garissa county indicated that Post-abortion (PAC) services are not offered in all the facilities within the county. The facilities that offer PAC services offer services such as counselling and family planning services. However, facilities that do not provide the services cited a lack of equipment and commodities to offer services.

> *"R: We normally provide family planning post-abortion care"* ***(Garissa Clinician 35)***

> *"R: We offer post-abortion care, youth service are offered also and youth friendly service is offered also offered"* ***(Garissa Nurse 27)***

> *"R: No, because we don't have equipment for PAC"* ***(Garissa Nurse 24)***

Similarly, in Narok county, the participants mentioned that the facilities offered post-abortion services (like providing antibiotics to the clients). However, for complicated cases, they made referrals to the county hospital because the facilities lack evacuation equipment.

> *"Like treating with antibiotics, we offer but sometimes we refer if it's a complicated case."* ***(Narok Nurse 39)***

> *"Yeah, we do, but we rarely do evacuation here, maybe if it's a serious case of which it's usually few cases. For the rest of the cases, we refer to Narok. You know for post-abortion you must have done the evacuation and we don't have the MVA kits"* ***(Narok Nurse 30)***

Sources of SRHR information

Older women and adolescent girls in Garissa County obtain information about sexual reproductive health from the facilities, at home or via the media. When these two groups visit the facilities, the healthcare providers they are often educated on SRHR through health talks. Those at home receive information from their neighbor's or during the community outreach and sensitization programs carried out by the CHVs. Radio is the mainstream media source that provides SRHR information to women.

> *"R: the information that they obtain the first index is the clients then you educate the client if its mother or Male person you can educate them both on the community information and facility setup information"* ***(Garissa Nurse 27)***

> *"R: The radio, health facility we normally have health talk and lecture with the facility concerning about reproductive health and all yeah and prevention of early pregnancy and all those we normally give health education then they normally castigate that information from local radio"* ***(Garissa Nurse 45)***

> *"R: through the radios, FMs and sometimes some organizations sometimes organized awareness towards the community"* ***(Garissa Clinician 30)***

In Narok county, most of the adolescent girls obtain information on SRHR from the internet and through their local youth groups. Most adolescents fear being stigmatized and therefore rarely visit the facilities to receive SRHR services. Thus they get information on SRH from the group and church meetings. Older women obtain information from the facilities, especially during their clinic visits. Additionally, both the women and adolescent girls get information during the community outreach events that are spearheaded by the CHVs.

> *"R: Adolescent girls usually get information from the internet and their peers they even prefer buying those drugs from the chemist, because they fear stigma, the stigma of why seeking such services and you are not eligible for them, age but for older women, because they come here for others services like child clinic, they obtain them at the facility. It's rare to see adolescent girls asking for those services."* ***(Narok Nurse 45)***
> *"Yes. We normally have youth groups. We go to churches after church and give health talks. And I also have community health volunteers. We normally send them during, especially when we have an outreach. For mobilization and we go and give them a health talk and the services if they need it."* ***(Narok clinician 30)***
>
> *"R: The older women are also included, because times when you are talking to the adolescents they are also there, Yeah. But the good thing with the older women, they also come to the facility and enquire."* ***(Narok Nurse 30)***

Unacceptable Circumstances of use of FP

Findings from the in-depth interviews showed that the use of family planning is considered to be against the cultural norms in Garissa, especially in the deeply remote areas. Men in Garissa prefer to have many children and therefore, women use contraceptives in secret. Where there is no partner approval, providers opt not to offer FP due to fear of being sued by the partners. There were also concerns about the possible side effects of contraceptive use. The participants mentioned that the use of family planning could result in cases of infertility, bleeding and delayed menses. Religion was another concern. The Islamic religion in Garissa county does not support family planning.

> *"R: There are a lot of them but gradually demystified them because some say like implants if you die with them it's wrong and some say will trouble your heart, okay some say it's going to change your menstrual cycle, some say means your fertility so this are daily challenges and will deal with their case to case basis as they arise you counselled them, you educate them more"* ***(Garissa Nurse 38)***
>
> *"R: Some of them come with some complaints that obviously most of it have side effects and we normally explain to them some of these side effects like heavy bleeding, nausea, headache so those are minor side effects of but if its major things like heavy bleeding for a long time so we normally tell them to come back but rarely get this thing, in case it happens to get it we normally addressed it and we know what to do."* ***(Garissa Nurse 45)***

> *"eeenh religious is obvious somebody's not according to the religion why should you access family planning services if you are not married because you may found yourself in an adultery or fornications so that is committed sins"* ***(Garissa Nurse 45)***

> *"R: Yeah in this setup most of people view family planning negatively and some people believe that if you do family planning you may end up becoming fertile still there is believe that family planning is associated with so many side effects bleeding as all those negative uptakes of family planning is actually practice setup some people saying if you get family planning you'll end up being not getting menses and end up becoming fertile all those beliefs are still available in the community against Gods will so most of the people still fear they have that fear of under organizing God will"* ***(Garissa Clinician 38)***

Similarly, in Narok county, the community believes that marriage meant for procreation. Therefore, they perceive the use of contraceptives to be against such norms. Most women, especially married women use family planning without the approval of their partners. There are existing myths and misconceptions about the use of contraceptives and their side effects. Some members of the community believe that the use of family planning may result in infertility. Some also believe that implants may cause harm to their partners during intercourse.

> *"R: So sometimes there are challenges in Maasai land where there is a lot of challenges. Sometimes women claim secretly minus informing their husbands so we are trying that is why we have to educate them on family planning that it's not bad it's just for spacing so that they can get nice people at the same time"* ***(Narok Nurse 40)***

> *"R: Yeah, I can say about the cultural norms, because they say the purpose of getting married is to reproduce so the men don't want women to use family planning."* ***(Narok Nurse 30)***
> *"Not really but I have ever heard one saying family planning causes cancer"* ***(Narok Nurse 39)***

> *"R: They are saying, anybody who has not gotten a child is not supposed to get family planning, again, religion, (wengine wanasema) others are saying, Christians are not supposed to use, such things"* ***(Narok Nurse 39)***

Reasons for low contraceptive uptake

Healthcare providers in Garissa county mentioned some of the possible reasons for the low contraceptive uptake. Some of the major reason highlighted included the fear of stigmatization, religious and cultural beliefs as well as the negative provider attitude. Community beliefs that women and adolescent girls using family planning are going against God's will for procreation was also rampant. Married women who use contraceptives risk experiencing tensions owing to the use of contraceptives leading up to divorce. Other key concerns were yths and misconceptions about the possible side effects associated with contraceptive use such as bleeding and infertility hence the fear using the methods.

"R: as I said earlier still people believe the myth that contraceptive is organizing God's will which most so most Muslim believers say why should I go against God's will and integrate his powers" ***(Garissa Clinician 33)***

"R: cultural barrier, the religious barrier again and the taboo and misconception associate with these things, they have fear to access these things" ***(Garissa Nurse 45)***

"R: the husbands they are against them. And you know the wife now is worried because if you take and the husband has not agreed. Now that comes, you even they can divorce" ***(Garissa Nurse 25)***

The barriers were similar in Narok county. The providers noted stigma, and religious, cultural beliefs and commodity stockouts as key barriers. The facilities always run out of the contraceptive commodities like condoms and other contraceptives. Similarly, there are issues of cost implications. The community members' financial low status makes it difficult for them to afford some of the family planning methods. Some of the healthcare providers do not have the knowledge and expertise to offer family planning services.

"R: I think it's the same case we must involve these chiefs to assist us because they just stay at home with problems minus coming here so that we can help them so need to synthesize and go for outside there and we talk to them in meetings so that they can understand about this thing." ***(Narok Nurse 40)***

"R: Number one, I think it cost, because we charge them here, so many of them do not afford for sure." ***(Narok Nurse 28)***

"R: I think it has to do with stigma, and less staff with less training skills, and also the restricted hours for the services." ***(Narok Nurse 45)***

Violence against Women

The participants highlighted some of the common types of violence against women in Garissa. Women and young girls mainly face physical and emotional violence. Young girls are victims of sexual violence such as rape and FGM and early marriages. In most instances, the perpetrators of rape are unknown to the survivor. On female circumcision, the vice is being encouraged even by the duty bearers like the chiefs who even have their daughters forcefully circumcised. Among women, domestic violence is the most common especially in rural areas.

*"R: This area may be just family dispute whereby you find men abusing women but not sexually. The sexual reports are not that much but this just local violence you may find man attacking a woman beatings these are the common ones" (***Garissa Nurse 27)***

"R: Those things happen in the community, they happen now what are you supposing to do I will cause a challenge you are the area chief your daughter is getting married she is sixteen years and getting married to another chief" ***(Garissa Nurse 38)***

> *"R: Female circumcision, early marriage and maybe wife inheritance and all those things are there in the community and sometimes most of them don't succeed eenh"* ***(Garissa Nurse 45)***

These cases of violence in Garissa county are handled differently and varies from one case to another. The survivors who are informed and knowledgeable are proactive and always take up the cases and report to the police stations or visit the health facilities to seek services. However, the majority of the women and adolescent girls either opt not to report the cases at all or handle the cases within the local community leadership structures. Those who opt to remain silent on the cases are always driven by fear.

> *"R: in our community that is settled by our elders, religious leaders they settled or finished at the community level"* ***(Garissa Nurse 24)***

> *"R: mostly because of fear of society or the norms of the society they don't come to get services they don't show up"* ***(Garissa Nurse 27)***

> *"R: they report to the facility I mean they report to law enforcement officer and police those things and in case they are really injured they seek for health services mostly done in the facility eeenh"* ***(Garissa Nurse 45)***

> *"R: Most of them actually what we receive and what happens around are actually different most of them may not get the report and see the problem and the only time that ladies they will come with and give and report for examples girls under the age of 18 defiled and end up staying at home and gender-based I mean domestic violence also still we have that challenges but people are not coming up ladies are not coming to report that there was gender I mean domestic violence at stay at home and the few that we get also end up going back to the same problem and coming back later on with the same complain so still there is a lot of challenges"* ***(Garissa Clinician 33)***

In Narok county, though cases of violence are not as rampant, there are still a few instances being reported. Cases of young adolescent girls being raped or defiled still exist in the community. In other areas of the community, girls still undergo FGM and early marriages. The women, still face physical and sexual abuse from their partners.

> *"R: Early marriages and FGM. From the community level, whereby they are still following their norms and bad practices of the past."* ***(Narok Nurse 28)***

> *"R: Most cases are assaults, a woman beaten by the boyfriend or the husband and then they come and report. The cases of rape are not high, but they are there. Also, defilement is there, but not much, I think that one should be next to rape, because it's not that much, you find it once in a while."* ***(Narok Nurse 30)***

Women in Narok county either report cases of violence to the responsible authority like the police or visit the facilities for medical examination and treatment in cases of sexual violence such

as rape and defilement. However, there are still cases where some women do not take action against while others opt to handle the cases through the local community leaders.

> *"R: Mostly they go to the police station first, then the police sends them here, here we assess, we do medical examination, we give medication, we write a P3 form then it's taken back. They get treatment and then the P3 forms are filled and then they go continue with the police."* ***(Narok Nurse 30)***

> *"R: They seek care and support from the facility and also the Hospital in this facility. And the police, the eeh police officers around. And the services offered, we normally come and eeh, first of all. We give the counseling. After that they go for the lab tests and investigation, for them to be done. Then from there we manage and treat the child."* ***(Narok Clinician 30)***

> *"R: Some solve their cases at home with the area chief. Others usually bring their cases to us.Especially nowadays, they know when you undergo GBV,they can get treatment, and they are now coming."* ***(Narok Nurse 45)***

Integrations of GBV services in routine SRH

Participants in Garissa had mixed responses on the feasibility of the integration of GBV services into routine SRHR. While some participants felt that it was a feasible and already happening, others felt that the facilities were not in a position to integrate services. They indicate that such facilities lack the necessary infrastructure for integration.

> *"R: yeah its we are doing integrated services because that is we do in this place we deal with normal reproductive health problems and also GBV so this place we deal with both reproductive health conditions mothers with reproductive health conditions and that is actually the back because the number of GBV case that we have is not that big to warrant at the department on its own so we deal with reproductive health and on top of that we also deal with GBV"* ***(Garissa Clinician 33)***

> *"R: I may yes, I may say no I say yes because the services can be offered because like any other services because we normally have normal injuries and all those violence within the community you attend to them so SRH and GBV services is not an exceptional we can still do it I'm saying no because most of the staffs are not trained on that and the facility may be having a shortage of maybe the resources to do those things may not be there so if there is adequate training and availability of those thing can be integration is will be fine and can be handled so we have staff we don't have skills to do that and the recourses is limited."* ***(Garissa Nurse 45)***

> *"R: ok for our case we are not integrated SRH/GBV services. We separate them SRH services, you find about GBV client to separate room. We make to reduce confidentiality clients"* ***(Garissa Nurse 27)***

Similarly, in Narok, integration of GBV services into routine SRH was received positively. While not many facilities implemented intergration, a few did indicate that it is an ongoing practice.

> *"R: Not really, but we will try, I think that register is just there but no cases recorded, nobody has ever think of filling it."* ***(Narok Nurse 28)***

> *"R: We have integrated because we are able to offer the services in one site. The one I was telling you about, we give post exposure prophylaxis without going to the pharmacy, also our clinicians are also able to remove sample inside the same room and able to test STI infections."* ***(Narok Nurse 45)***

Challenges to integration

While the facilities in Garissa county are open to embracing integration, there are underlying challenges that may hinder smooth integration. Some of the challenges mentioned by the healthcare providers included issues of inadequate staffing, lack of appropriate infrastructure, inadequate space, and inadequate skills to handle such cases. In addition, there are key concerns with supply of commodities and equipment like drugs and reporting tools.

> *"R: Just the lack of training and lack of supplies and commodities we are not involved whenever there is training"* ***(Garissa Nurse 25)***

> *"R: staffing Yeah we have limited staffs only two we don't have the resources and those two staff are the ones with the skills to do all that so we are not adequately trained most of us eeenh unless the one we learned through our university education but specifically on GBV we don't have like today if I'm told to do screening i will do it what i have learnt in school but current update..."* ***(Garissa Nurse 45)***

> *"R: challenges is knowledge gaps, there is no training recently actually we are waiting the based one also such kind of stigma at a times you don't even exposed some of the cases so it may fall the knowledge gaps and also literacy"* ***(Garissa Clinician 35)***

Similar challenges were highlighted in Narok county. The healthcare providers stated that the facilities do not have trained staff who can competently handle cases of GBV and this is worsened by the lack of adequate training. There were also issues of inadequate space at the facilities as well as lack of the necessary commodities.

> *"R: The challenges number one is the commodity, the commodity is not available. And then to integrate, maybe the space. I think there should be a room that should be used for that."* ***(Narok Nurse 30)***

> *"R: Training is a big issue because we have currently, err since (inaudible 00:09:02-00:09:05) training concerning the gender-based violence. So we need to to polish our management skills."* ***(Narok Clinician 30)***

> *"R: The biggest challenge I can say is enough trained staff, when we talk of GBV,it would be better if all the staff are trained well,I can also say,the services will move faster."* ***(Narok Nurse 45)***

Suggested improvements

Healthcare providers in Garissa County made suggestions on how to make integration of GBV into routine SRH provision successful. First, is to capacity-build staff on GBV. Also, training through CME staff as well as other job training activities coupled with frequent and consistent supervision. The other suggestion was to conduct health education and sensitization within the community so that they are able to embrace these services. To address the issue of commodity stockouts, they suggested a consistent supply of the equipment and commodities as well as the reporting tools.

> *"R: And the availability of services within the facility if those services are there the community should be involved like now somebody might come to me here and be raped I will even refer them to the go to the general hospital so the recourses should be available and the community should know that the services are available here and staff should be trained on that"* ***(Garissa Nurse 45)***

> *"R: We also need equipment, we need those materials, we need reporting books and the like the other services"* ***(Garissa Nurse 38)***

> *"R: one important thing is that actual system to improve and so that we don't have to go out in actually performing and hoping that other services to the other patients and to have limited space and also the other thing also to be done mostly is more training and more staffs"* ***(Garissa Clinician 33)***

Similar sentiments were echoed by providers in Narok county. Other than training additional staff, supply of commodities and community sensitization, they indicated that improvement should be made to the referral system.

> *"R: Maybe about the referral system, when you refer a patient it should be clear where you refer the patient, because sometimes you are not sure where you are referring the patient to."* ***(Narok Nurse 30)***

> *"R: Service quality, we can improve by at least getting the (pauses to think) eer training so that we can improve our work skills and the commodities availability should be throughout. We should not run stock out of commodities."* ***(Narok Clinician 30)***

GBV barriers Care seeking services

Healthcare providers in Garissa County opined that high poverty levels was a common barrier. Stigma was another noticeable barrier. Most women opt not to share their experience in violence due to fear of being stigmatized by society. Others mentioned barriers were long distances to the facilities and lack of awareness and information by the community members of survivors.

> *"R: issue of seeking because of stigma somebody may say let me not go treat undecided that is of the delays the second is the distance from the facility, the facility may be far somebody maybe outside some villages out there, the other one is the person may not have the money two transport may not be their vehicle to take like sometimes yeah let me say as our catchments areas go up to some kilometers ennh."* ***(Garissa Nurse 45)***

> *"R: yeah that is already community barriers like people feeling it should be shameful to report others feeling that the court seeks very long time and community what we called the community gases system called them Maslah (meaning negotiations of elders)"* ***(Garissa Clinician 33)***

In regard to the health facility level barriers, the providers pointed out a number of issues. Most of the facilities are experiencing staff shortages. The few staff that are available are not able to handle the workload. There is also a general negative provider attitude towards handling GBV cases since most providers do not want to be part of court cases. A good number of the providers have not been trained nor sensitized on issues relating to GBV. The facilities are also lacking the necessary tools and equipment to handle GBV cases in addition to the frequent stockouts.

> *"R:lack of commodities pharmacy the drugs the investigations aspect even items to used take sample might not available sometimes it ends up rendering the service provider"* ***(Garissa Clinician 33)***

> *"R: eennh staff training could one of the causes of problem two staff may be train but types of equipment to handle the case might not be there because of limited recourses eenhh"* ***(Garissa Nurse 45)***

Similar sentiments on community-level barriers were echoed by providers in Narok. A vast majority of GBV survivors are from poor backgrounds and cannot afford the cost of the services. The facility distance was also a concern given the sparse distribution of the facilities in the county, the survivors walk over long distances which is odious for many. Stigmatization and language barrier was the other noticeable concerns.

> *"R: yeah barriers sometimes it is roads. Sometimes we have a lot of rains here we cannot see clients coming because of the roads they are very poor. Sometimes they are unable to reach the facility."* ***(Narok Nurse 40)***

> *"R: Yes, sometimes this place is far for them, some don't even go to Lolgorian, they just come here, and they can stay at home because of distance, it could be a challenge"* ***(Narok Nurse 28)***

Further, providers in Narok highlighted the gap in providers' training to handle GBV cases. The human resource was the other major concern. Most facilities are understaffed with the available staff bearing with a heavy workload. There were also reports of inadequate medical supplies in the few existing facilities.

> *"R: Lack of the commodity, also the community sometimes. Because I had a case of a man bringing the wife to remove the implant and the child is 6 months old."* ***(Narok Nurse 30)***

> *"R: lack of confidence, comes when one is not well trained and also cost, this is a public hospital, some commodities get out of stock but the cost is not a challenge unless travelling from far and it can be a challenge."* ***(Narok Nurse 45)***

Improving GBV and SRHR services

To improve SRHR and GBV services, healthcare workers in Garissa county are engaged in aactivities that are aimed at educating and sensitizing the community. They also undertake mobilization of the community to increase the uptake and utilization of contraceptives. Similarly, they do awareness campaigns against GBV like FGM and early marriages.

> *"R: the role of health care workers is get provide what we called health sperm and giving the information that the kind of services that are available in our facilities when the health care providers does that it does who are available for them then there will be some information that will go out that those services are available and its provided so that is the role of health care worker"* ***(Garissa Clinician 33)***

> *"R: doing awareness and educating them there is nothing else, doing awareness in the churches and mosques and the schools we do alot of awareness I hope those thing can be preventing"* ***(Garissa Clinician 35)***

> *"R: By mobilizing the community and educating them about the importance of family planning"* ***(Garissa Nurse 27)***

The providers from Narok county highlighted their roles to mainly include community advocacy. They create awareness on SRH and GBV services in the community.

> *"R: It's to do a lot of community advocacy and awareness in this area and also community like chiefs."* ***(Narok Nurse 45)***

> *"R: There should be creation of awareness for GBV services."* ***(Narok Nurse 30)***

Gaps to contraceptive uptake and GBV prevention

Pursuant to the responses from the in-depth interviews, Providers in Garissa county mentioned that there exist gaps that hinder the uptake of contraceptives. One major gap is the community knowledge. The community members should be sensitized to be more aware of the available contraceptive methods as well as their accessibility. The facilities are also located far from the community members and even the few available facilities lack the commodities to provide contraceptives.

> *"R: ok in our case maybe for family planning and GBV what we lack is only emergency contraceptives yes if we get those ones we would be very busy for us this cases would be very easy for us to prevent maybe unwanted pregnancies early pregnancies and for the*

referral for the clinical and medical in that area we don't have a problem the only problem we have is the emergency contraceptives" ***(Garissa Nurse 27)***

"R: People should just show the availability of services where to seek and all those things eenh through the local radios, yeah the community most of them don't know where to seek those services, two eennh like stigma and discrimination is common eennh so people should know that these things are something that happen against like an accidents eennh like accidents happen to you today do you need to hide and you have broken legs" ***(Garissa Nurse 45)***

"R: yes the gaps are most of time the drugs are not available and lack of health care workers and also the community barriers that we talk about so if those things are addressed and we are able to" ***(Garissa Clinician 33)***

A key concern expressed by the providers in Narok was the healthcare workers' attitude. They mentioned that some providers are rude to the clients. Therefore, most clients do not open up on their needs when they visit the facilities. Others shy away from visiting such facilities. There are also issues of knowledge gap in the community on contraceptive use.

"R: Yes, there are gaps because you see maybe I'm concerned about the culture of the community. They are, some of them they are against getting the contraceptive services. So what maybe we can be doing maybe is educating, giving education concerning the matter of the contraceptives so that they can stop the myths. Yes." ***(Narok Clinician 30)***

"R: You know sometimes, you may come, and then I speak to you in an unfriendly manner, you won't come again, or you may decide to just stand and leave." ***(Narok Nurse 30)***

"R: I think as health workers we are supposed to also create awareness, to tell the community the services that are there, and you offer…you know there are patients who prefers one on one conversations about the different FP methods. I think the availability of the staff also to conduct health talks." ***(Narok Nurse 30)***

Addressing Challenges

In order to bridge the gap on contraceptive uptake and GBV prevention, providers from Garissa county suggested that there should be adequate supply of commodities and equipment to make them available and easily accessible to the community. The facilities should also designate areas for SRHR and GBV services. This will ensure clients privacy is maintained. Similarly, the community should be sensitized on GBV and SRHR. The awareness creation should be done through health education via the following channels: media and community outreach activities. In addition, the facilities should be given additional staff while the existing staffs should be trained on contraception use and GBV prevention.

"R: this can be addressed through radios when doing a lot of awareness through the barazza through the mosques and churches" ***(Garissa Clinician 35)***

> *"R: Is community empowerments, community education, build capacity for CHVs then we have follow-ups in the communities, we punish the perpetrators so that others may learn from them."* ***(Garissa Nurse 38)***

> *"R: Like now making the services to be available, easily accessible to them keeping their privacy"* ***(Garissa Nurse 25)***

Similarly, in Narok county, the providers suggested that there should be an adequate supply of commodities and equipment to make them available and easily accessible to clients. Sensitization and awareness creation on GBV and SRHR should be done through health education via the media and through community outreach activities like village barazas.

> *"R :Having enough health workers, and trained to effectively handle such cases, also by having debriefing sessions to update the nurses. Also, men involvement, because sometimes, and mostly involving GBV, they are left out, so if we combine advocacy, awareness and men involvement, then this challenge can be better."* ***(Narok Nurse 45)***

> *"R: Eerm the challenges, we can address them through our Sub-County. Maybe they can provide us help with the family planning. We order on time so that we can have the commodities on time also. Yeah."* ***(Narok Clinician 30)***

> *"R: Male involvement, but you see most of the men are found in Barazas, there was a time we used to tell the chief that when the men are sited there, he should call us to go and talk to them because they need to be involved. They need to know that we are not telling their women they should not give birth and that we are telling them that they should plan."* ***(Narok Nurse 30)***

GBV community perception, awareness and attitude

In Garissa county, providers of reported mixed opinions on community changes on awareness, perception, attitude and care seeking of GBV and SRHR services. A good majority of the providers were of the view that there has been a positive change in the community. This they said is evidenced by the increase observed in the number of people seeking SRHR and GBV services at the facilities.

> *"R: Yeah. Like now I have seen people coming for family planning services. Others come seeking advice counselling."* ***(Garissa Nurse 25)***

Similar views were held by the providers from Narok county who said that women and adolescent girls have become more aware of GBV and SRHR services. The cases of GBV are currently being reported unlike in the past 12 months. However, some providers felt that there was no change in the attitude and perception of the community.

> *"R: Yeah, most of them report, at least most of them report. Even if it doesn't go anywhere most of them report."* ***(Narok Nurse 30)***

> *"R: Yes, the changes we have occurred, at least right now we have the family planning commodities. We go for outreaches whereby we can give our health talks and give the services also. Mmh"* ***(Narok Clinician 33)***

Changes in the health system

Providers in Narok County reported some changes in the health systems capacity to provide quality services to the GBV survivors. Through the trainings, capacity building workshops and sensitization meetings, the providers have been empowered with the knowledge and have started to take up cases of GBV. Improvements were also noted in the provision and supply of equipment and the construction of additional structures in some facilities within the county. However, some providers had contrary opinions. They felt that no change has been experienced in the health systems.

> *"R: Yes because currently we have only family planning commodities whereby the last time we had some stock out of some commodities and also we have the lab commodities available so we can manage the cases"* ***(Narok Clinician 30)***

> *"R: There has been trainings so at least most of the health workers are capacity built also at Narok referral hospital there is a GBV desk."* ***(Narok Nurse 30)***

> *"R: I have not seen any change, since I have not seen any support they are giving us.They just ask if there is any case,would you manage,and nothing.The rest usually come and say this is a private hospital and you can buy for yourself. The only things they provide is family planning but not mostly, I can't say they have not helped but,they need also to see somethings and help us.Those staff can be active and do extra but with not update training they can't."* ***(Narok Nurse 28)***

Similarly, in Garissa, the providers reported having experienced similar changes to those observed in Narok. However, some felt that the health systems have not experienced any changes since the facilities still lack the equipment and commodity to handle cases of SRH and GBV.

> *"R: Yes over the last two years there have been several training done over the same there will be improved capacity of health care workers and there is also one done for CHV over the same so there is a lot of changes being done allot of awareness' we also have nowadays that like children's officers initially we don't even know them nowadays we have their numbers we know whom they are we meet during CHVs meeting they form part of us at least there is that going on and there is a big step in this sub-county."* ***(Garissa Nurse 38)***

> *"R: Stayed the same because there is no lack of that room equipment for them"* ***(Garissa Nurse 25)***

Data Collection Limitation

This report finding should be viewed on the basis of how the FGD, IDIs and KII guides were designed, the settings in which the data was collected and the quality of transcription that aligns with qualitative research. Where gaps are observed at any particular stage of data collection and quality control, it is likely that achieving depth and richness of data is unlikely. Below are observations that should have been considered during and after data collection.

- Controlling social-desirability bias: Field data collection and the senior research team should have observed that in West Pokot and Garissa Counties, there was a tendency of FGD participants to answer questions in a manner that would be viewed favorably by other peers.

- Observing social political and cultural dynamics that are natural settings. Field data collection and the senior research team should have taken cognizance of the group matching dynamics between Christians and Muslims and held separate FGDs in Garissa for these two communities.

- FGD participant interview settings. Listening to both audio and reading through the transcripts it is clear that participants seemed not to have seated in line with FGD data collection techniques. Owing to this overlap it made it very difficult to have a candid discussion between the interviewer and the participants, especially in Garissa County.

- Adherence to qualitative data collection settings and interviewing techniques. From both the audio and the transcripts, it appears that the interview venue was not favorable, where the FGDs were conducted, and not private. This affected the richness and depth of data. Also, the interviewers were not probing into areas for exploration which greatly affected the context, especially in key areas of exploration.

- Adhere to qualitative standards of transcripts quality control and completeness. The field data collection never checked the quality of transcripts, conversely transcript quality in West Pokot and Garissa is of poor quality, and they need to be reviewed for quality improvement if they are to be used for future qualitative analysis.

Recommendations

- Support community-based organizations and women's groups through SBCC channels that create local community grassroots chapters to educate women of reproductive age on the need and importance of using contraceptives across all four counties. Findings from right holders elucidate worrying trends of naïve women not knowing the importance of using long-term contraceptives and their benefits. The focus should be mounted on LTFP Implants and copper IUDs coils.
- Address the perennial stock-outs of long-term contraceptives preferred by women in rural counties. Also, address suspicion and negative myths about coils by educating women and men on their importance including providing trained health providers who are knowledgeable in the service provision of coils.
- Enhance youth-led intervention that promotes YFS-SRHR services among the youthful generation at the sub-county health facilities through innovative SBCC strategies that involve both girls and boys at the community level in Garissa and West Pokot counties where social-cultural norms were prevalent.
- *Support and work with social media peer education programs implementing SRHR programs*
  As observed from the findings, largely access to online digital contraceptives services where done by peers and friends through several online pathways, it will be important to develop or work with existing community networks of peer-led interventions and recruit social media peer educators to support demand creation for online digital youth-friendly products, while conducting SRHR educational sessions through the online peer community.
- Strengthen SRHR services at the point of care to ensure that survivors of SGBV optimize comprehensive care and treatment services: Findings from the key informants CHVs show that at the sub-county health facility lack of essential medicines such as analgesics and antibiotics essential for the care and treatment of survivors of SGBV is a critical component that needs to be addressed. Taking note that only comprehensive services were available at the county health facilities which required additional resources to access these needed services for survivors of SGBV
- Continued sustained SGBV interventions in Rural Kwale, Narok, West Pokot and Garissa Counties while optimizing male engagement strategies through SBCC: Findings from right holders and male engagement shows that primary participants were of the opinion that male engagement interventions targeting Men young and older in having candid conversations on contraceptives pathways and SGBV discussion would greatly enable positive behavior change and enhance awareness of FP choice when men become champions of Family planning ambassadors.
- Support and enhance trauma counseling training for service providers at the sub-county health facilities who will provide the necessary psychosocial support for survivors of SGBV
- Support sub-county facilities with the provision of an evidence collection package that allows specimen collection and storage to support legal representation.
- Support and enhance a paralegal community-based network of Women that empowers Women and girls to have the confidence and report cases of sexual and gender-based violence.

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Appendix I

Findings from Accelerate Stakeholders in Narok and Garissa

Role in Accelerate program Narok and Garissa

Findings from the group discussions with CBOs in Garissa county revealed that the main role of CBOs is to sensitize the community on SGBV and SRH. This they do through conducting community outreach activities across the county.

> *"R: Sensitization of the community on SGBV and reproductive health."* ***(Garissa-CBO-FGD)***

In Narok county, the CBOs were involved in educating and sensitizing the community on issues of GBV and SRH. They informed the community on the importance of contraceptive use, especially among youths and adolescents to prevent early teenage pregnancies. In addition, they are involved in community empowerment programs that are aimed at improving the economic status of the community members. Such economic programs include training on income generation activities such as soap making, beads making and catering. The CBO also undertake campaigns against FGM and early marriage among adolescent girls. These outreach activities are carried out through door-to-door campaigns as well as via the media platforms like radio.

> *"R: We teach them the importance of using family planning and the issue of early pregnancies. We also encourage those that have already got early pregnancy not necessarily get married. The girl can still go back to school and go ahead with her life of schooling. We also inform the alleged perpetrators that they should be caretakers of the girls and take them as their sisters and ensure they're not always caught on the cases like those of being reported to the police."* ***(Narok-CBO-FGD)***

> *"R: According to my understanding, the main duty in the community as a CHV the first thing is to create awareness in the community about the health of the body, and home sanitation, secondly we do things to do with GBV/Domestic violence. Another thing that we do in the community is to deal with issues of security in the community. Another thing we do as CHVs is mostly deal with clean toilets/sanitation and clean water. We also create awareness about HIV in the community."* ***(Narok-CHV-FGD)***

> *"We do women empowerment programs where we empower women to do their own activities like beading, catering and soap making."* ***(Narok-CBO-FGD)***

Received support

Pursuant to the discourse with the CBOs in Garissa county, the participants indicated receiving support from the accelerate program. These included capacity building of the CBO staff, facilitation of the outreach activities through provision of IEC materials as well as facilitation of their transport. The program also supervised the CBO's activities. Also, the duty bearers were

supportive in mobilizing the community members to attend the outreach meetings in addition to preparing the venues for such meetings.

> *"R: It also helps us and… in terms of like if we were to do a sensitization in the community, they facilitate our transportation."* ***(Garissa-CBO-FGD)***

> *"R: What we were supported is just during the training we were given certain materials."* ***(Garissa-CBO-FGD)***

In Narok county, the participants appreciated the support they received from the accelerate program which has been supportive in the day-to-day activities of the local structures by providing them with IEC materials as well as training and giving stipends to the staff. The duty bearers have also been supportive of the CBOs and CHVs. The duty bearers have acted as gatekeepers; they provide linkage between the local structures and the community members by mobilizing the community and also directing the CBOs and CHVs on where to find clients.

> *"R: The program has helped us in sustaining the program by providing us with materials like supplying with reflector jackets and we have T-shirts, and caps with messages like 'Stop FGM'. So the moment an individual reads the messages a conversation is started and we can therefore pass the message. Secondly, it has helped us with accountability we have got good relations with the duty bearers and the health workers, they are now aware of PS Kenya. We now have a good relationship we as a CBO and the duty bearers."* ***(Narok-CBO-FGD)***

> *"R: Yeah, we usually go to chiefs' meetings/events also we get support from churches on school holidays when they have conferences we attend and they support the program. But the youths request to have programs that provide sanitary towels and other items."* ***(Narok-CHV-FGD)***

Implemented activities

The participants in Garissa county indicated that the CBOs has implemented community outreach and dialogue programs aimed at sensitizing the community on SRHR and GBV. These outreach events have been carried out in churches, schools and mosques.

> *"R: Yes, we have them; we have the outreaches events."* (***Garissa-CBO-FGD)***

> *"R: Yes, during the events; the supported events whereby the community comes and give their feedback about it."* (***Garissa-CBO-FGD)***

In Narok county, the CBOs and CHVs have carried out sensitization and awareness campaigns on SRH and GBV. They have engaged with the bodaboda operators to help reduce cases of teenage pregnancies and rape as they are considered the leading perpetrators of such violence. Women and young girls, have been educated and sensitized on contraceptive use and informed on the available channels to seek justice in case they face GBV.

"R: First we have created awareness on sexual reproduction rights, whereby many youths were not aware that there is a law that protects them and they have a right for access to health services in government facilities. We facilitated the availability of youth desks in collaboration with government hospitals. Also, the women have not been aware that there were places where they could report when violations were done to them, and now they can go and report domestic violence cases through awareness." ***(Narok-CBO-FGD)***

"R: I have been visiting my community to inform them if these things happen there must be a repercussion and the effect of people engaging on things that infringe other people's rights. For example, in the previous year, I had some students who were impregnated and I followed up until the students gave birth and went back to school and were not married off, I also ensured that the culprits were brought to justice to ensure those cases come to an end." ***(Narok-CHV-FGD)***

Effective Accelerate activities

Findings from the discussions with the CBOs in Garissa county show that the program in conjunction with the CBOs has effectively used a collaborative approach in dealing with cases of GBV and its associated conditions like fistula. The program has supported the CBO to conduct outreach events. Similarly, the referral systems have been strengthened and the CBO staff are receiving incentives for doing well.

"R: People were able to identify how SGBV; specifically, FGM is contributing to fistula." ***(Garissa-CBO-FGD)***

"R: The approaches whereby you know, how we have incorporated the programs." ***(Garissa-CBO-FGD)***

In Narok county, the one-on-one community dialogue sessions as well as the engagement of women in discussions of GBV and SRHR in the absence of their male counterparts have resulted in many women opening up and disclosing their challenges. The GBV campaigns have also resulted in many people being linked to the appropriate authorities to access justice and health care. The communication component has also been lauded for being effective. This has seen information effectively flow from the program to other stakeholders like the duty bearers, the CBO and the communities. There has been an enhancement in the collaborative attitude of the stakeholders and hostility from the community has also been reduced.

"R: There has been a good communication channel and they've created a good rapport with the county government hence it enables smooth interactions with the chiefs and the community leaders and gatekeepers. The hostility has been ended due to PSK and county government health departments working together and eases our work as a CBO." ***(Narok-CBO-FGD)***

> *"on the issue of GBV I have some experience. I once heard some alarm and responded and found out that a man was beating his wife; I inquired what the cause of the quarrel was but male asked me to inquire from the partner. I asked the perpetrator that even if he did something you are not supposed to beat your partner because she is not a child. So I will take the action and take her where she is supposed to justice, the problem arose when the wife started to plead with me to forgive the husband and she would talk to him and he would change. I told her if we forgive him he would come back and beat you again tomorrow and it would be a problem. So they joined hands and they pleaded with me to forgive them but what I have seen success there is since that day the quarrelling has never happened again and since they're in my neighborhood I make sure it doesn't happen and do follow ups."* ***(Narok-CHV-FGD)***

Challenges Encountered

CHV/CBO level

In Garissa county, the FGD participants noted that the CHVs were not trained on the project's scope. For those that were trained, they felt that the training was inadequate as they were only trained for 2 days. They also experience shortages in commodities and equipment to effectively carry out their mandate.

> *"R: We have other guys who are supposed to be trained in the project, you know those who are cognizant with the community. We have CHVs who have linked the at an organizational level and Ministry of Health. Were no trained." (**Garissa-CBO-FGD**)*

> *"R: In short, the number of training was very minimal." (**Garissa-CBO-FGD**)*
> *"We are supposed to have the commodities. Some facilities don't have commodities." (**Garissa-CBO-FGD**)*

In Narok county, there were concerns about CHVs shortage, especially within the urban slum areas where the CHV to household ratio is very low due to the dense population in those areas. Similarly, in rural areas, households are sparsely populated making it difficult for a CHV to cover the vast areas. Further, they raised issues with the delayed payments of their stipend. Such delays take up to 3 months and this negatively affects their morale. The key concern was that while the program disburses the payments in time, the leadership holds on to the money and diverts it to other uses instead of paying the CHVs. Finally, they felt the training was inadequate and was not done as per the work plan.

> *"R: On the issue of the workforce, you'll find out that here in urban areas estates are vast for example total area, Majengo areas you find that the households are many as compared to the number of the CHVs in that area. Secondly in rural areas, even if we have that number of 1950 CHVs in the county our county is very vast you'll get that some villages even aren't aware of what a CHV is but only know a doctor since they have never interacted with or seen the work of a CHV. So when CHVs conduct tasks like immunization they usually think it is the doctor who is doing it, they don't recognize the CHVs because*

they are not covered. Another challenge is, for example, I am working as a CHV in a certain area and I'm being barred from accessing the opportunities, when a chance comes in and there was some allowances to be reimbursed you'll find that politics chip in and maybe see an elder bringing his daughter, chief brings his daughter or his kin because they heard there is something. But when it was a volunteer job there wasn't anyone available and they recognize you but if there are any allowances they will deny you totally. Therefore, the major challenge that we have is we need to be independent and be able to work on our own." ***(Narok-CBO-FGD)***

"R:To add on that, you find on the organization level there are several organizations that take advantage of top CHVs they come here and use CHVs on the ground but when the money comes it is diverted elsewhere and the money was signed by the CHVs. So the CHV has nowhere to go because she may not even have a contact person to call." ***(Narok-CHV-FGD)***

Community level Challenges

Participants from Garissa county noted that they lacked the necessary logistic support to aid in the provision of SRHR and GBV services to the community. Transportation across the county has become a challenge due to the increased fuel prices. Further, the community exhibits a knowledge gap on SRH and GBV. This has resulted in the CBO staff facing rejection and hostility whenever they visited the community to create awareness.

*"R:Now that because fuel has hiked and all that, things are not the same." (****Garissa-CBO-FGD)***

*"R:At the community level the challenge is that there is the lack of the knowledge; the knowledge gap at the community level. That is why we are saying the books should be translated." (****Garissa-CBO-FGD)***

Local structures in Narok county demonstrated that one key challenge was logistics. With the hard economic situation, most of the CHVs and the CBO staff cannot cater for their transportation around the county. The CHVs also work in fear; specifically, in cases of GBV where the perpetrators are often released and opt to seek revenge on the CHVs who took up the case. Further, the participants highlighted other community-related challenges including the community knowledge gap on SRH and GBV, long distance to the facilities, religious and cultural beliefs and practices as well as community elders interfering with the justice process.

"R:I can say one, we have issues of logistics and lack of funds, and for example, a village you were accessing at KES 400 has been adjusted to 600 due to the high cost of fuel. Then the organization's way of reimbursing the money takes a longer period. For example, we're at the month of September almost getting to the next month, so if the stipends are delayed for the next sessions or activity, this will be a challenge to go forward with activities, this has caused life to be tough. Another thing we have now is a new

administration and you will find a lot of leaders of departments will be changed, we will have now to go a new introduction and create new rapport with the coordinators. So we are not aware of how the new administration will receive us." ***(Narok-CBO-FGD)***

"R:On the issue of SGBV, this has created enemies between us and the families of those affected. So we don't have anyone to protect us even the government laws that says when I'm working there in the community I will be safe. Because one on FGM when a CHV goes to report, in our community they take the issue of FGM as a right and a girl must be circumcised. When the culprit is nabbed and the information is leaked you will be discriminated from that community and when maybe in future you get a problem nobody will need to associate with you. You will be viewed as an intruder both as a CHV and even in churches since even in churches we emphasize people not to marry young children or do FGM but sad thing this issue continues. You find that I only take that initiative alone including using transport or go on foot but there is no any compensation at all that I will go and do that job and on the end of the day you may sign and get reimbursement or getting comforted in any manner so there are many gaps." ***(Narok-CHV-FGD)***

"R:Maybe there are challenges of victims fearing to come out and speak due shyness. And also the issue of community elders taking bribes and hindering justice from the victim just because the elder has accepted five hundred shillings from the perpetrator." ***(Narok-CHV-FGD)***

Consortium level

The CBOs in Garissa indicated that they do not have a formal engagement with Accelerate program. While they continue engaging the community through outreach and sensitization activities, they are yet to formalize this with PSK.

"We haven't gotten an official from the consortium. Unlike what we have been doing, Ali has been bringing us activity but that is not activity." ***(Garissa-CBO-FGD)***

Common challenges

Logistics was the major concern raised by the participants from Garissa and Narok counties. The counties are vast in area and have very poor transport infrastructure making it difficult for the CHVs to move around. Issues of community stigmatization especially among the women coupled with the male chauvinistic culture of the communities in these counties was another key concern. The community members also have a knowledge gap on GBV and SRHR issues.

"R:Yes. Then the third challenge should be Illiteracy or lack of awareness on their SRHR." ***(Narok-CBO-FGD)***

"R:I can say it's the logistics as the number one challenge from us as a CBO and the community members. You see as much as we try to create awareness on the communities there is an issue of distance to the facility and low turnout on awareness meetings.

*Secondly, we can have issues of stigma when a woman has been involved on GBV when she goes to report the family will see her as an outcast. There is also an issue of deeply rooted culture whereby women have no say in the community. You'll find that women cannot disclose to their partners that they are going to get the contraceptives which are a good service to her; she'll end up going without permission and later lead to conflicts on the family." **(Narok-CBO-FGD)***

Mitigations to the challenges

To manage these challenges with the community in Garissa, the participants suggested the program should engage other stakeholders like the area chiefs and village elders to help with community entry strategies. Similarly, the program should provide refreshments during the outreach activities as a token to the community members that attend the events. For the challenges facing the CBO, they suggested that the engagement between the CBO and Accelerate should be formalized and the staff to be capacity built for effective service delivery. They also suggested that the training manuals and other IEC materials should be translated to the local Somali language.

*"R: Also there is need before we go to the community, we approach the gatekeepers, Elders, chiefs and all those so that when we go they make the community entry simple." (**Garissa-CBO-FGD)***

*"R: So you have to show them pictures and all that and if all those things are not translated in Somali it is a bit hard but what we do is we tend to give them that information verbally in our own way." (**Garissa-CBO-FGD)***

Similarly, in Narok county, the participants suggested training of CHVs on communication skills to allow them to enable them create rapport with the community and avoid rejection and hostility. The CHVs should also be motivated through stipends and reimbursements. A stakeholders meeting should be organized so that the different partners can familiarize themselves for easier coordination. The program should continuously supply the necessary commodities to avoid stock outs.

*"R: For the last 3 months to 8 months' condoms are not available, we used to give them for free but nowadays they are no longer there. We just tell them to buy, but if we get an organization that can bring the condoms it can be a bigger boost to them because they are danger." **(Narok-CHV-FGD)***

*"R: We should be brought together so that everyone recognizes one another and when I vast the village I know we have a nyumba kumi `and we need to work together." (**Narok-CHV-FGD)***

"R:We have trained more TOTs (Training of Trainers) so they have more knowledge of the program and also the approach of using all sectors like the Bodaboda guys, and the Muslims, the elites in the community and the young people. This has enabled us to pass the information on using the local dialects." ***(Narok-CBO-FGD)***

"R:There should more awareness and educating the community on their social accountability and include all the stakeholders like the duty bearers, the perpetrators and the victims. So in summary we need to engage the community through community dialogues because so far they're working." ***(Narok-CBO-FGD)***

Findings from Accelerate Stakeholders in West Pokot

Role in Accelerate program

The FGD findings show that the CBO and CHV local structures engage in community sensitization programs that aim to address negative and harmful practices FGM. They also educate the community on sexual reproductive health, more specifically on the availability, accessibility and use of family planning services. In addition, they act as champions against gender based violence directed at women, youth and adolescents in the community. The community sensitization and education programs on SRHR and GBV are undertaken through community outreach activities as well as via social media activism.

"R: Okay mmmmh maybe us in West Pokot county most people lack information so as like youth champion we impact knowledge to this people on things to do with SRHR, GBV, FGM, Child protection so for them to get those information or what to do and not what to do ,yeah" ***(WP-CBO-FGD)***

"R: All of them have been said but also i play role by using media platforms by championing the need of following accelerate program through media as well as poster because you know the society is large those who cannot read we read them through media as well as posters we post around the community." ***(WP-CBO-FGD)***

Support Received

Through the accelerate program, the CBOs have been supported through trainings and sensitization on issues around Sexual reproductive health and gender based violence. The program has also supported the CBO financially by sponsoring their outreach activities and also providing transport reimbursement during the community outreach activities. Similarly, the CBOs have received support from the local duty bearers like the area chiefs, village elders and the community health assistants who help with the mobilization of community members during the outreach meetings.

"R: I can say that eeeh this people have been of much benefit to us since because before we go to the community eeeh we meet with them first and tell them that we will be having

an activity within the community so that they will do for us the sensitization so we find that when we go to the community to do this activities we find that we have large number of people the youths and adolescents coming to attend this functions yea because they have told the community on what we are coming to do and also when it comes to maybe when we go for the family planning data collection In the hospital eeeh the nurses whom we always reach to eeh always talk to people always telling them that youth champion from declares Kenya would be coming do some.. okay…before …like when taking the data they will be coming to you people on family planning ,HIV testing,cancer screening and importance of doing such tests yeah." ***(WP-CBO-FGD)***

"R: so like the accelerate program has given us enough information …, we started with the training, capacity building of how to engage with the community about how to pass the information to the community, then also give us the financial assistance to reach out to many people because of those outreaches, those transport reimbursement, so those are some of the major investments." ***(WP-CBO-FGD)***

Implemented activities

From the discussions, the CBO mentioned having successfully rolled out social media campaigns through Twitter. They have also been able to effectively carry out outreach activities aimed at sensitization and awareness creation at the community level. It is through these activities that women, youths and adolescents have been empowered with information and knowledge on SRHR and GBV. The end result has been increased access and uptake of contraceptives in addition to actions being taken against GBV perpetrators while the survivors get assistance.

"R: I will say one of the accelerate programs we have implemented let's say the Twitter chart so we can say we have implemented that because we usually ensure we use Twitter chart actively maybe after sometimes weekly or monthly championing accelerate program through Twitter because we would like to bring the society together and the need to advocating against gender-based violence, children rights, advocating for need to use family planning, advocating for women in matters relating to socio-economic or cost sharing" ***(WP-CBO-FGD)***

"R: on outreaches you see the methods of family planning and HIV testing becomes a challenge to the youths so when they see us the youths are frontline to talk on this matters they find it safe for them to engage more on this matters so whenever we go to or having an outreach they normally come in large numbers ,we are age mates so we can speak the same language ,we understand them and they understand us so there is no discrimination like if I am an old woman ill tell her you are a small girl why do you want to use family planning but when she comes to me and we are the same she finds it safe for her" ***(WP-CBO-FGD)***

Effective accelerate activities

The CBO has effectively carried out community sensitization campaigns. The community has gained information and knowledge on contraceptive use. This is evidenced by the change in perception and attitude of the male population towards contraceptive use in addition to the willingness portrayed by the youths to uptake family planning services. On the consortium level, their mode of communication was highlighted to be very effective. Through the creation of WhatsApp groups, the program has been able to pass information more effectively and conveniently.

> *"R: To add on what she has said what we have impressed well is male engagement when it comes to contraceptive use like the past you could not address a man on family planning but now on their own they want to be told about family planning so that is a great achievement ."* ***(WP-CBO-FGD)***

> *"R: Thanks to our CBO intervention we have been able to feed the community with information like when I come from home to work here every morning when I meet these footballers at the field they ask me when I will be back to teach them like they have loved being fed with information like many youths at my village they loved having sex with the use of condoms but now I have like two to three packets of condoms now they call me, like a brother when they want to access condoms, sometimes back they usually struggled to reach Kapenguria health facility to pick condoms"* ***(WP-CBO-FGD)***

> *"R: I can say ahhhhh flow of communication has been a good improvement, we have a common whatsapp group whenever it happens immediately we get information on our to perform sameance at West Pokot county they update us from PS Kenya so the information that is clearly given to us as CBO level then it means the involvement between the CBO and PS Kenya has played a role, also at the community the level they will always ask why have you not come today or when are you coming it means the information flow is constant ,if I get feedback from the community the CBO will communicate at the same on WhatsApp group or phone call, I think the information has played a bigger role."* ***(WP-CBO-FGD)***

Encountered challenges

CBO/CHV level

In west Pokot, the facilities lack commodities and equipment such as phones for data collection, SRH and GBV products to provide the required services. The participants also complained about reimbursement delays. They indicated that this had a negative impact on their morale to carry out the outreach activities. It is from the reimbursements that they get to pay for their transportation around the community. The unfavourable climatic condition of the region coupled with the impassable road network during rainy seasons is another concern for the CBOs. This hinders them from accessing the community hence they cannot effectively carry out outreach activities during such periods.

> *"R: reimbursement does delay [people laughing] that is what motivates the champions when payment delays there is some challenge from running the activities so at the high level it means there is a challenge, they have to do something, for example, we have not*

been paid for last two months so there are some people who will lose moral" ***(WP-CBO-FGD)***

"R:Okay the challenges that we have encountered is mostly when we do our in-reaches most these facilities they lack commodities so at the point we might not have data for 2 or 3 weeks, collecting data becomes hard because they lack commodities, the other challenge is some of the communities they don't want to be taken photos it becomes hard to justify that we did an activity" ***(WP-CBO-FGD)***

Community level Challenges

From the discussions, the participants highlighted rejection by the community members who perceive contraceptive use to be a taboo and against their traditions and cultural beliefs as the major challenge. Further, they faced challenges with the elderly population. In most instances, the elderly perceived them as children who should not be giving advice to the elderly. Similarly, the community was not open to discussions on sex as it was viewed as sacred and should not be spoken about openly.

"R: the other thing is when talking to these people the rejection level is high when you want to talk to them they prefer their culture, you try to tell them about family planning and they say it's against their taboo, so its challenge since we want to educate them but they don't want" " ***(WP-CBO-FGD)***

"R: To add on what R2 has said, there are the elderly, sometimes we target people about 30 years, we were somewhere where some men who were saying that we are like their children how comes we are giving them advice on family planning so you see like you cannot continue that conversation but it is a challenge to convince them that sometimes information can come from below to upwards." ***(WP-CBO-FGD)***

"R: one of it is that some of the communities do not want to associate with us there is that stigmatization, they will view us, as those people who talk about sex because to them family planning is not a great thing to talk about the community openly, like sex is not something to talk about openly so to some level to reach such people becomes hard because they see you as that guy who talk about sex, they don't want to associate with you so at the end of the day it distorts the flow of information" ***(WP-CBO-FGD)***

Common challenges

The common challenges for the local structures in West Pokot that needed to be addressed urgently are the issues of stipend payment and reimbursements in addition to supply of commodities and equipment to the facilities and the CBOs.

"R: I can say that reimbursement is a challenge not even for me alone but all of us Who are champions who take part in the project in the community. In the reimbursement, they need to do something because that brings the morale to work." ***(WP-CBO-FGD)***

Mitigations to the challenges

To address these challenges, there were suggestions to provide reimbursement and refreshments to the community whenever they attended the outreach meetings. In addition, IEC materials should be availed as well as motivators such as reflectors and lesos. These would motivate the community members to spare their time and attend such meetings. The outreach activities should also target leisure parks where most people would be free and having the time to listen to the teachings on SRHR and GBV.

> "*R: When you're also mobilizing the youth and adolescents you have to buy them something like sweets, biscuits and Juices so that they can sit down and listen to you so you have to spend from your pocket. Now it's reached a point where you don't have anything so you have to borrow from a nearby shop so that they can come to listen to you because there is no other way to help such a situation or influence them to accept.*" ***(WP-CBO-FGD)***

> *"R: Another remedy is that you will have to go to the Stadium where people are just sitting doing nothing. Those people are willing to listen to you and in the stadium, people are dormant so we use that opportunity because they don't have anything to do."* ***(WP-CBO-FGD)***

Appendix II

ACCELERATE RESEARCH DISSEMINATION AND COUNTY ENTRY MEETING AT HORIZON HOTEL IN KAPENGURIA, WEST POKOT COUNTY – 21/11/2022

Summary of salient:

The summary below presents the details of the successful stakeholders meeting at Horizon Hotel, in Kapenguria town, West Pokot County. The main agenda of this forum was to disseminate the research agenda that was conducted in the Rift region. There was an impressive representation of stakeholders (over 40 persons) including representation from health, education, gender, persecution/police (ODPP), NCPD, CBOs, DESIP partners and media houses across the 3 counties in the North rift region. During the meeting, evidence from the health facilities, duty bearers and community perspectives were shared and discussions around them were constructively insightful. Besides exhaustively presenting the agenda of the meeting and moderating discussions that emanated from the same, there were focused deep-dive discussions with the counties to map the way forward/action points. However, the research findings were taken very positively by all counties present at the time of the meeting.

Among the top-level gaps identified for actioning included the underlisted:

1. *Program to strengthen the link between health workers and police/prosecution – including sorting out whole issues of misunderstanding between the two players. ODPP is more than willing to support training/capacity building on forensic GBV component*
2. *Health providers are unwilling to fill out PRC forms for many reasons, among those are: they are not facilitated to attend the court session, and due to police harassment, which sometimes is extended to the survivors and directly to the health workers themselves. Solutions: see point #1 above, and there seems to be a fund available from the judiciary for the witnesses which health workers should benefit from.*
3. *Male engagement is extremely crucial to ensure the West Pokot community is embracing contraception. This is where the problem lies to break the pattern of low acceptance*
4. *SGBV reporting: County records officer acknowledged that GBV documentation is extremely very poor in the counties. Counties seem to be having limited copies of new reporting tools which may not have been distributed to the facilities. Partners were invited to support the dissemination and printing of enough copies.*
5. *Need for focused research on key populations/PWDs on SRHR/GBV.*
6. *Requested for similar dissemination following round 2 data collection*

Introductions were done chronologically by Departments and County of Origin: Introductions were made according to the Counties and different departments being represented. This is a summary of the departments represented:

1) *Baringo Team HMT - CHRIO and CHRC*
2) *Baringo Gender Officer*
3) *Directors of education from Baringo and Elgeyo Marakwet*
4) *National Council for Population and Development*
5) *National Police Service - Baringo*
6) *Seniour Public Prosecution Councils from Baringo and Elgeyo Marakwet*
7) *Media - North Rift Radio, Rift*
8) *Media - Kokwe Radio*
9) *Media - Kale Radio*
10) *West Pokot Team, HMT*
11) *Declares Kenya – Team*
12) *County Commissioner – Area County Commissioner West Pokot County*

13) *HRI – Project Manager*
14) *Accelerate – PSI, PSI Independent consultant, PS Kenya, GVRC and DESIP Team*

There was a wide multi-sectoral representation from Baringo, Elgeyo marakwet and Baringo Counties.

- *It was shown that Accelerate Project's Impact, otherwise expressed as CYPs Annual Targets for the rift cluster, had a performance of 104% (Baringo 111%, Marakwet 106% and West Pokot 92%).*
- *There was also commendable reach on Adolescents even though more efforts need to be directed towards more reach.*

Presentation on Demand creation was done by Joel from GVRC and more emphasis was used to explain school interventions revolving around Murals and speak boxes.

- *Welcoming New CHMT Members to DESIP interventions, especially from West Pokot County.*
- *A recommendation proposed to ensure Sustaining program gains made by the DESIP despite reduced resources, needed to be explored by partners.*
- *It was recommended that stakeholders needed to ensure male involvement is explored for participation and contribution to impactful gains.*

Research findings by Mr Julius of PSI.

The presentation's agenda would explain the research background, learning questions

Sampled West Pokot, the findings should also reflect Elgeyo Marakwet and Baringo. An early intervention study was done, mid intervention study was done in 2023 and a final study in 2025. Going to the same facilities for all 3 studies.

West Pokot-27 health facilities studied.

Key Responses: Julius Njogu:

- *All addressed in the slides and then further elucidated.*
- *It was mentioned that there was detailed and extensive training of locals as RAs, with locals that were conversant with local dialect – to conduct the research as data collectors.*
- *There were Multiple levels of supervision, with coders, there were audio and digital recordings and transcription of audio digital recordings for an accurate account of all responses.*
- *There was the use of consent and observation of client information confidentiality. All qualitative data were analyzed using software called D-Doose.*
- *Involve policymakers to deliberate on the issues mentioned to address gaps and drive action.*
- *Involvement and consideration of LGBTQI were off the table for the researcher now, but it is an area that can be pursued in future.*

Presentation made by PSI Independent Consultant

- *Qualitative presentation made with content that is comprehensively elucidated.*

Response from NCBD Baringo

- *It was said that Women do not prefer condoms, both male and female condoms.*
- *Issue of Male Boda Boda taking advantage of young girls - call for the community to take precautions against the Boda Boda menace.*

Response from Julius:

- *It is argued that Adolescents are scared of accessing Condoms from public facilities due to fear of meeting relative and being told on, fear of stigma and being judged.*
- *Additionally, most young people are on methods, especially ECs (P2) and Condoms that are dispensed from private clinics.*

Comments from CRHC - West Pokot

- *It was noted that there was a lot of mistrust from young people regarding their openness to access FP methods. Young men are buying drugs for their girlfriends.*
- *Adds that HCWs have a lot of work to ensure that the right process for access to FP services is observed.*

Response from independent Consultant:

- *Different religions have different views on the matter. Islam mentioned as one with a different view*
- *SGBV and IPV – analysis underway. There is an intersection between users and perpetrators in Kangaroo Courts and Rape*
- *Rape is happening and elders are solving the cases with a fine of livestock, inhibiting legal redress*

Response from Julius:

- *He believes the issue of male involvement needs to be deliberately addressed.*

Comments from NCBD

- *Guidelines on male engagement can be supported by accessing previous research that was conducted and can be accessed on NCBD Baringo Website.*
- *Comments from GBV Focal Person - Baringo*
- *Recommends professional and dignified handling of GBV victims*

Response from SDPP – Baringo

- *Privileges - Client advocate (lawyer and Client, Priest, and Communicant, Medical Practioner and Patient unless acting under orders in support of his work).*
- *These were guidelines to be understood when supporting GBV victims during law enforcement and rehabilitation. All matters of undignified handling of victims to be guided by these privileges, this can be made doable through collaboration among medical personnel, law enforcement and DPP's Office*

Closing remarks from the different County Directors

West Pokot – Director Gender Services:

- *Appreciates excellent job done by partners and community involvement. Acceptance and endorsement of research findings from West Pokot County.*
- *Calls for a multi-sectoral approach to the management of GBV services. Calls for a more multi-sectoral approach to support GBV interventions*
- *Lack of mention of Political wings as inhibitors to the uptake of Contraceptives and GBV, has a bearing on outcomes within the same space.*
- *There is no gender Policy in West Pokot. The process was started but due to political twists, the issue was never concluded.*
- *A lot of work needs to be done within GBV space due to high level of ignorance to GBV issues.*
- *Evidence of GBV needs to be supported to support cubing of these practices.*

Closing remarks from Accelerate - Ms. Gladys Someren

Speaking on behalf of Senior Manager, Accelerate.

- *Registered her appreciation to the efforts and blessing from respective CHMTs, for allowing Accelerate Entry, Implementation of projects and Research and further coming back to accept and endorse feedback from Accelerate.*
- *Appreciation to PSI, Partners and Independent consultant for a commendable job that gave a tip of the iceberg on what is actually fairing in West Pokot Counties.*
- *Her take home was that, with collaborative interventions and implementation through a multi-sectoral approach, then there would be no limit to possibilities of success within GBV space.*
- *She admonishes a multi sectoral approach towards ending GBV.*

ACCELERATE RESEARCH DISSEMINATION AND COUNTY ENTRY MEETING AT PRIDE-IN HOTEL IN UKUNDA, KWALE COUNTY – 24/11/2022

Summary of salient:

Kwale invited stakeholders were mainly attended by participants from the county including Deputy County Commissioner, MOH- CHMTs/SCHMT, gender, Police department, among others. Our findings generated interesting discussions as listed here below:

Deliberations:

1. **CASCO, Kwale**: Qualitative findings indicate IUDs are viewed negatively by the community across the counties in that they cause injury or discomfort to male partners during sexual intercourse. What does evidence point at, is it a myth in the community or something related to provider lack of skill such that devices are not inserted appropriately?
2. **County Research coordinator, Kwale**: Qualitative data indicates SGBV is associated with shame and stigma? Could this be the reason why the Dispensaries are recording low case loads as survivors are compelled to seek for services elsewhere which is far from their homes (in towns/hospitals)?
3. **County Research coordinator, Kwale** From qualitative data, do we know what's the magnitude/burden of males who are facing GBV from women partners – what kind of violence and what motivates this violence?
4. **Police Commander, Kwale**: Qualitative evidence indicates low use of FP among young girls in Kwale, leading to unwanted pregnancies which is now most young girls are procuring abortion services. What can the health workers do to prevent teenage pregnancies and avail access to FP services among adolescents? We should not live in denial Ministry of health to provide directives.
5. **DSW Representative/RH coordinator Msambweni**: We should also report CHV led community dialogue meeting have worked really well whereby they hold GBV meetings in the community
6. **DSW Representative**: We should separate opinions by age: It was mentioned that younger males who are sexually activity in Kwale oppose contraception while older men have embraced it. This is really an interesting comment from a participant, as we have observed the contrary in other counties.
7. **Stawisha Pwani Representative:** How did the study collect data regarding supportive supervision. Did we just ask the questions to the providers or did we also validate from facility records as supervisors typically record details.
8. **County Deputy Commissioner (Kwale):** Mentioned that they do dispense male condoms at their place/offices which are always in huge demand among the youth. They also receive requests if they can also issue out female condoms which they do not stock. Can PS Kenya donate female condoms to them?. HIV coordinator also mentioned that female condoms have high demand among key populations and PS Kenya could also donate if they have them in stock.
9. **County Deputy Commissioner (Kwale):** Reported communities are complaining that the "Red coloured" male condom, which is distributed free of charge, is laced with HIV virus and is of poor quality – this is starting to propagate negative narrative to the extent of affecting male condom use. What we can we do to validate or disapprove this claim before is too late?
10. **County Research coordinator, Kwale**: Mentioned that these findings need to be disseminated to the CHMTs who majority were unattendance to help shape county level decision making/policies – particularly recommendation for laboratory capacity and PEP services among dispensaries which are really lagging behind
11. **CASCO, Kwale**: Sought to understand more where there's a gap in IUD services in the facilities? How does lack of equipment or skill gap affect services that much compared to implant services? Training is generally needed

12. **Stawisha Pwani Representative:** Although the facilities do not typically stock P2 products, providers should be made aware, but they can still use other pills such as COCs in their right dosage to serve as "ECP"
13. **Stawisha Pwani representative:** How the research defined eligible participants for emergency therapies, ECP, PEP and STI? Did ineligibility criteria contribute to the amount of missing data being reported? Also sought to understand how were the missing data established (decided to be) in PRC and SGBV register during data extration?
14. **Stawisha Pwani Representative:** What are the recommendations for service improvement

Appendix III

Data collection Guides

FGD Guide – Local Structures (CBOs and CHVs)

Version date: 22 July 2022

Session ID number: [_____]	Date of interview: [_____]
Start time of interview: [_____:_____]	End time of interview: [_____:_____]
County name: [_____]	Name of moderator: [_____]
Location of the meeting: [_____]	Number of participants: [_____]
Local structure (CBO/CHV) [_____]	Audio available: Yes or No [_____]

Introduction: Read out

Hello, my name is _____. I am part of a research team conducting interviews on behalf of Population Services Kenya (PS Kenya). PS Kenya is a local NGO dedicated to improving health and saving lives.

Thank you all for coming here today and for agreeing to take part in this focus group discussion. As we mentioned, we are gathering information from selected community-based workers (i.e., CHVs and staff from CBOs) to learn about the issues of sexual reproductive health and rights in this community. Information gathered from this activity will be used to support health and wellbeing of women and girls in the community.

As we start this focus group, I would like to highlight a few important points.

- We encourage everyone to contribute freely to the discussions. All your opinions and perspectives are valuable to us.
- Participants should respect others even if they disagree. A participant who is verbally or physically aggressive or hostile towards (or threatens) another person in the meeting may be asked to leave the meeting.
- There is no judgement in this meeting in that there are no right or wrong answers. We are looking for your honest responses to our questions.
- We request you to speak one at a time so that we can hear what each of you is saying.
- We request that do not to refer to each other by real names, instead use your proxy or pseudo names throughout the session
- We request that we keep everything mentioned here today confidential. Do not divulge to others who are not here today about what we discussed.

- We encourage that you narrate experiences using examples without mentioning or naming anyone specifically.
- We have emphasized that every effort will be made to safeguard your responses from unauthorized access, all information that you will provide will remain strictly private and confidential to the study team.
- We request to record the discussion for purposes of report writing
- The discussion will last approximately 60-90 minutes, slightly less or more
- Do you have any questions or comments before we start our conversation?
- Our discussion will start now. Do I have your permission to record?

First, we will talk about what your roles in the Accelerate program, then focus on your experiences rallying communities around the issues of sexual and reproductive health and GBV

1. What are your roles in the Accelerate program?
    - Probe: SBC? community dialogue meetings and outreach events?
    - Probe: Besides Accelerate activities, which other community services/activities do you engage?

2. How has the Accelerate program, local duty bearers, and community supported you or your CBO to carry-out Accelerate related roles/activities? Probe about:
    - Accelerate program: Training, supervision/mentorship, IEC materials, etc
    - Duty bearers (chief, nyumba kumi, police, CHAR, etc)?
    - Community?
    - Others?

3. Since your engagement with the Accelerate program, which Accelerate activities have you or CBO implemented in your respective sub-counties/communities?
    - Probe: SBC activities such as community dialogue meetings and outreach events (elaborate)

4. Thinking about your CBO engagement/your engagement as CHV in the Accelerate SBC activities. Are there things which have worked well so far? Which ones and elaborate why?
    - Probe: CBO/CHV level
    - Probe: Consortium level
    - Probe: at community level?

5. Thinking about your CBO engagement/your engagement as a CHV in Accelerate SBC activities. Are there challenges, gaps, or barriers that you have encountered (these may be current or historical)?
    - Probe: CBO/CHV level –
        - Staffing issues (lack of training, few staff, staff turnover, lack of materials and equipment, supervision, motivation/recognition, or any other)?
    - Probe: Consortium level –
        - Challenges with technical support (supervision support, training, facilitation, etc)?
    - Probe: Community level –

- Logistical, advocacy, unintended negative consequences such as insecurity, unreceptive community, entrenched social norm and religious beliefs?
- Probe: If mentioned multiple issues, please rank your 1st, 2nd, and 3rd most challenging situations

6. If mentioned multiple issues, please rank your 1st, 2nd, and 3rd most challenging situations (in Q5 above).

   - How have you addressed (1st, 2nd, and 3rd) challenges? (Tackle one problem at a time)
   - Have you changed tact/approach to mitigate or address the challenge?
     - Why and what did you do? (Please narrate with examples)
   - If not addressed, what are some of the potential remedies to these challenges?
     - What has hindered change of tact or approach?

7. Now thinking generally about the Accelerate program areas where you have community activities What changes, if any, have you seen in the community in the last 12 months related to sexual and reproductive health and rights, GBV and harmful traditions? Elaborate the changes with example without mentioning people's names.
   - Which changes at the community level:
     - Social norms related to acceptance of contraception? What about those related to that normalize GBV and HTPs?
     - Youth and women empowerment? – Awareness of rights, practicing their rights, and reporting of GBV
     - Male involvement? How are they involved?
     - IF NO CHANGE: Why do you think there no change?
   - Changes within the duty bearers (chief, police, CHAR, teachers, religious and cultural leaders), justice system (formal and informal)?
     - Engagement/collaboration?
     - Access to justice?
     - IF NO CHANGE: Why do you think there no change?
   - Changes within the health system? and referral system?
     - Accessibility?
     - Referral system/ services linkage?
     - IF NO CHANGE: Why do you think there no change?
   - Why do you think these changes have occurred?
     - How has Accelerate contributed to this?

8. What strategies, interventions/activities, etc., would you recommend be sustained/scaled up, or need to be adopted, to positively influence SRHR including GBV/HTPs changes in your program areas? Please provide justification for your response.

9. Thinking about SBC and access to sexual and reproductive health and rights services. Do your CBO/activities/reach or support marginalized groups, and how?
   - Persons living with disability (PLDs)
   - Orphans and vulnerable children (OVC)

- LGBTQ+
- Others

Concluding remarks

- Do you have any other thoughts that you would like to add, or experiences you haven't yet shared that you think is valuable?

- Thank you very much for your time and sharing your views. All information that was provided will remain strictly private and confidential to the study team.

Providers IDI Guide

Section 1A: Provider Information	
ID1a. Interview date and time Date: [___|___]-[___|___]-[___|___|___|___] *[captured automatically by the device]*	**ID1b.** Start Time (in 24hr clock): [___|___] : [___|___] **ID1c.** End Time (in 24hr clock) : [___|___] : [___|___] *[captured automatically by the device]*
ID2a. Interviewer's name [_____]	**ID2b**. Interviewer's code [___|___]
ID13. County [_____]	**ID4**. Sub-county [_____]
ID5a. Health facility name: [_____]	**ID5b**. Interview ID [_____]

Introduction: To be read out after obtaining verbal consent.

Thank you for agreeing to take part in this interview. As I mentioned, we are gathering information to learn from health workers around the issues of gender-based violence (GBV) and sexual reproductive health (SRH) services. Information gathered from this activity will be used to support health and wellbeing of women and girls in this community.

As we start this focus group, I would like to highlight a few important points.

- You are encouraged to contribute freely to this conversation. All your opinions and perspectives are valuable to us.
- There is no judgement in this conversation in that there are no right or wrong answers. We are looking for your honest responses to our questions.
- We request that, when sharing an experience, not to mention anyone by real names
- Confidentiality: We will NEVER identify you by name when reporting our results – we will only be reporting the results of this discussion anonymously together with other respondents' answers. We may report direct quotations, or things that you say during your interview, but these quotations will never be linked to your name or anything else that could identify you.
- We request to record the discussion for purposes of report writing
- The discussion will last approximately 40-60 minutes, slightly less or more
- Do you have any questions or comments before we start our conversation?
- Our discussion will start now

As we start the conversion. I will now begin recording the interview.

First, we will talk about what your qualifications, position, and roles, in this facility. We'll then have a deep dive conversion around services delivery.

1. Please tell me, a few important information about you.
    - What is your age?
    - What's your health cadre/qualification?
    - What is your position in this facility?
    - What are your roles in this facility/What type of services do you provide?

- If not mentioned: probe what are your roles in SRH/GBV
- How long you been at the facility (in years) – count all years in the facility.

2. What kind of GBV and sexual reproductive health services are offered at this facility?
Probe for each, if not offered ask why?
   - Which gender-based violence (GBV) services?
     - Probe: medical examination, laboratory and treatment services, psychosocial support, legal support, rescue to a safe space/shelter?
     - If they provide GBV services: How does this facility identify GBV cases?
       - Probe: Does this include routine screening for GBV related complaints among women and girls seeking services in this facility? If not, why?
   - Which methods of family planning/contraceptive are routinely provided?
     - Probe: Which are the most commonly offered/dispensed method (youth vs. older women), and why?
     - Probe: Are you currently offering both the implant and IUD insertion services? If not, why?
   - Post-abortion services (PAC)?
   - Youth friendly services?

3. Now, I would like you to think broadly about sexual reproductive health of women and Adolescent girls in this local community (use the following probes):
   - Where do they typically obtain SRH information from (Adolescent girls vs older women)?
   - Are there circumstances in which it is unacceptable or viewed negatively for women to use family planning?
     - *Probes: socio-cultural norms, myths and misconceptions, certain methods (explain why), Not married, too young, married but without children, partner's disapproval, promiscuity concerns, side-effects, religious reasons?*

4. In this facility, how often do you see adolescents (15-19 years old)? What types of services do most adolescents request?
   - What are the reasons for low contraceptive services uptake among this group?
   - What do you think can help improve contraceptive services uptake among this group?

5. Now, I would like us to discuss about the violence against women and girls in the local community (use the following probes)
   - What are the common types of violence do women and girls experience? Where do most cases come from?
   - When women and girls are exposed to gender-based violence, what do they typically do?
     - Probe: Where do they seek care and support, and what services are provided in these places?

6. I would you to think about integration of GBV services into routine SRH services.
   - Is integration of GBV and SRH services feasible/practical in your facility context?
     - If no above: Why is not possible (lack of trained staff, lack of supplies, equipment, and infrastructure, etc.)

- If yes above: Please give me example/s of how your facility has integrated GBV into SRH services?

- What are the biggest challenges to integrated GBV and SRH services? (Probe: staffing, training, supplies, infrastructure, etc.)
  - What solutions have you found to those challenges? [Tackle each challenge at a time]
  - What else can be done to improve service quality and integration efforts?

7. **Clinical case vignette: Sexual violence**

I would like you to imagine a hypothetical case. An adolescent girl aged 15 years was brought to this facility with a complaint that she was sexually assaulted by a middle-aged man who is a well-known person by the survivor. The girl was on her way to school this morning when she was raped. The girl was found crying and in pain at the place of violence, near a bushy section of the road, by two women who were heading to the market. The two women assisted to bring the girl to this facility for care and support, but they have not reported the incident to the police or area chief. The girl is still visibly shaken and has multiple soft tissue injuries.

- If this is a real patient presenting to this facility today:
  - How would this facility manage this case? Please explain all steps that would be taken to provide needed care and support to the survivor.
  - Are there circumstances that would prevent providing some of the care? What is the care? And why? *(Probe: lack of equipment or lab, lack of supplies/treatments, lack of trained staff, linkage to support, etc.,)*
  - How does this facility report these cases of sexual violence? Would there be challenges in documentation and reporting this case? *(Probe: lack of reporting tools, lack of skills using the reporting tool, etc.)*

- Generally, in this subcounty, are there circumstances that would make health workers hesitate to manage a case of gender-based violence including sexual, or physical? Explain why?
  - *Probes: Stigma, client without police report/P3 form, fear from the perpetrators, lack of training, lack of supplies and equipment, unwillingness to fill PRC form, court, and legal justice related concerns?*

8. Generally, in this community, are there barriers that would prevent women/girls from seeking or accessing quality and timely GBV related health services?
- What are the common barriers?
- *Probe community barriers: social norms? Awareness and availability of services? e.g., logistics (distance, lack of money/transport, etc,?*
- *Probe health system barriers: limited local capacity eg., stockout of commodities, lack lab services, lack of trained providers? quality of services/ lack of confidence in services? cost? non-integrated services?*

9. Thinking about the roles that the health workers can play to improve acceptance and uptake of SRH services, and GBV prevention, support, and care?

- Are there gaps that should be addressed to improve, acceptance access, and quality of contraceptive services?
- GBV prevention, case detection/identification, and linkage to care and support, including violence related to intimate partner violence, FGM, child marriages?
- What challenges do health-workers face while playing these roles?
- How can these challenges be addressed? (Tackle one issue at a time)

10. As we wind up, now I would like you to broadly think about the situation of gender-based violence in this community. Has the problem of GBV in this community gotten worse, better, or stayed the same in the last 12 months?
    - What particular types of gender violence have gotten worse, better, or stayed the same?
        - Why do you think these have changed/not changed?
    - Have you noticed any changes regarding awareness, perceptions, attitudes, and care seeking related to GBV? What examples can you discuss that show this change?
    - Have you noticed any changes regarding health system capacity to managed GBV cases in this sub-county? What examples can you discuss that show this change?

Concluding remarks:

- Do you have any other thoughts that you would like to add, an experience you haven't yet shared that you think is valuable?

- Thank you very much for your time and sharing your views. All information that was provided will remain strictly private and confidential to the study team.

Male Engagement – KII guide

Version date: 24 March 2022

KII number: [_____]

Date of interview: [_____]

Start time of interview: [_____:_____]

End time of interview: [_____:_____]

County name & Location of interview: [_____]

Name of Interviewer [_____]

Respondent*: CBO, CHV, Duty bearer, Leader, etc* [_____]

Audio available: *Yes or No* [_____]

Introduction: Read out

Hello, my name is _____. I am part of a research team conducting interviews on behalf of Population Services Kenya (PS Kenya). PS Kenya is a local NGO dedicated to improving health and saving lives.

Thank you for agreeing to take part in this one-one discussion. As I mentioned, we are gathering information from community duty bearers, leaders, and other stakeholders around the issues of sexual reproductive health and rights in this community. We also interested in hearing what roles can men and boys in the community play to support wellness of women and girls. Information gathered from this activity will be used to support the health and wellbeing of women and girls in the community.

As we start our conversation, I would like to highlight a few important points.

- I encourage you to contribute freely to the discussions. All your opinions and perspectives are valuable to us.
- There is no judgement in this meeting in that there are no right or wrong answers. We are looking for your honest responses to our questions.
- You don't have to answer anything which you don't want to.
- I request to record the discussion for purposes of report writing.
- The discussion will last approximately 30-45 minutes, slightly less or more.
- Do you have any questions or comments before we start our conversation?
- Our discussion will start now

First, we will briefly talk about **your position and roles** in this community. After that, we will discuss about some of the issues regarding family planning, and then violence against women and girls.

SRH Module

1. What is your position, and roles in this community?

- What roles have you had in SRHR or GBV prevention and response?

2. In this community, is it typical for women to use a method of family planning (regardless of their age, duration/status of relationship, number of children)? Why?

    - Is it ever unacceptable or viewed negatively for a woman to use family planning? Why?
        - Probes: Not married, too young, married but without children, partner's disapproval, promiscuity concerns, side-effects, type of a method, religious reasons, gender, economic and cultural norms, expectations of the number of children a family should have (example: more children may indicate may be viewed as a sign of prosperity)?

3. What do most men in this community typically think about women's use of family planning?

    - Are men/boys generally supportive of or opposed to contraceptive use? Why?
    - Are circumstances in which it is unacceptable for women to use contraception?
        - If yes, what are those circumstances? Probes: Husband disagrees, not married, too young, side-effects/type of a method, religious reasons, etc.
    - Do men typically believe they need to give permission or approvals from their sexual partner/wives to use or obtain family planning? Why?
    - What is the typical attitude of most men/boys towards male condom use in this community? Does it differ by age? how?

GBV Module

4. Have you heard/seen violence being perpetrated against women or girls in this community?
(Probe here on all different types of violence if they only list one or two types (physical, sexual, rape, emotional, VAC, FGM/C, IPV, forced/child marriage, etc.)

    - What types of violence are typical/common?
    - Which groups are most at risk? (Probe: Age, economic status, sex-workers), Why?
    - Usually, where and when (time of day) does most violence occur?
    - Who are the typical perpetrators (without mentioning or naming anyone)?

5. In this community, are there circumstances in which male use of violence against women/girls is viewed as an acceptable norm?

    - If yes, what are those circumstances and what types of violence are considered acceptable by the community (probe why for each)
    - In what situations are women blamed for the violence because of their behaviors or attitudes? [probe, have them explain or provide examples]

6. Why do you think some men in this community are violent toward women/girls, including their wives/partners?

    - What factors that may influence men to act violently against girls and women?

- How is masculinity viewed in your community?

7. What does this community (as a whole) do to protect women and girls from gender-based violence? What services are locally available (if any)?
    - Probe for domestic violence /intimate partner violence, sexual violence (rape and defilement), traditional practices (female circumcision, forced and early marriages)
    - Probe for activities by community – community groups, religious groups, elders, health workers, etc.
    - Are men involved? Explain how?

8. Are there any barriers to seeking care and reporting GBV cases among women/girls in this community?
    - If yes, what are the typical/common barriers?
    - If not mentioned probe: *stigma, acceptance of violence as normal, logistical (cost, distance, hours of operation, etc.), lack of awareness of services, lack of trust in the benefits of services, lack of confidence in justice systems/corruption, lack of follow up, or quality of services?*
    - If mentioned multiple barriers, please rank the 1st, 2nd, and 3rd commonest barriers

9. Now I would like you to broadly think about the situation of gender-based violence in this community. Has the problem of GBV in this community gotten worse, better, or stayed the same in the last 12 months?

    - What particular types of sexual violence have gotten worse, better, or stayed the same?
        - What changed and what has caused it?
    - Have you noticed any changes regarding awareness, perceptions, and attitudes of GBV among community members? What examples can you discuss that show this change?
    - Has there been a change in the response and support for the survivors (i.e., medical, and justice)?
        - Probes: What changed and what has caused it?

SRHR situation and future recommendations

10. What is currently being done in this community to improve wellness of women and girls in relation to their sexual reproductive health and rights, including preventing the problem of GBV?

    - How has these efforts engaged men and boys?
        - What has worked well?
        - What challenges have you faced?
    - How could these efforts be improved? Specifically, what can:
        - Male leaders/groups do or be engaged?
        - How about husbands?
        - How about boys and youth leaders?

Concluding remarks

- Do you have any other thoughts that you would like to add, or a story/experience you haven't yet shared that you think is valuable?

- Thank you very much for your time and sharing your views. All information that was provided will remain strictly private and confidential to the study team.

Male Engagement – FGD guide

Session ID number:
[_____]

Date of interview:
[_____]

Start time of interview:
[_____:_____]

End time of interview:
[_____:_____]

County name:
[_____]

Name of moderator:
[_____]

Location of the meeting:
[_____]

Number of participants:
[_____]

Gender & age group of participants:
[_____]

Audio available: Yes or No
[_____]

Introduction: Read out

Hello, my name is _____. I am part of a research team conducting interviews on behalf of Population Services Kenya (PS Kenya). PS Kenya is a local NGO dedicated to improving health and saving lives.

Thank you all for coming here today and for agreeing to take part in this focus group discussion. As we mentioned, we are gathering information to learn from people of your age and gender around the issues of sexual reproductive health and rights in this community. We also interested hearing what roles can men and boys in the community play to support wellness of women and girls. Information gathered from this activity will be used to support health and wellbeing of women and girls in this community.

As we start this focus group, I would like to highlight a few important points.

- We encourage everyone to contribute to the discussions.
- All your opinions and perspectives are valuable to us. Participants should respect others even if they disagree
- There is no judgement in this meeting in that there are no right or wrong answers. We are looking for your honest responses to our questions.
- We request you to speak one at a time so that we can hear what each of you is saying.
- We request that do not to refer to each other by real names, instead use your proxy or pseudo names throughout the session
- We request that we keep everything mentioned here today confidential. Do not divulge to others who are not here today about what we discussed.
- We request to record the discussion for purposes of report writing
- The discussion will last approximately 60-90 minutes, slightly less or more
- Do you have any questions or comments before we start our conversation?
- Our discussion will start now

First, we will talk about what you know or heard about **family planning** in this community.

SRH Module

1. What can couples do to control when to have children and how many children to have?
    - Which modern contraceptive methods do you know?

2. In this community, is it typical for women to use a method of family planning (regardless of their age, duration/status of relationship, number of children)?
    - Is it ever unacceptable for a woman to use family planning? Why?
        - Probes: Not married, too young, married but without children, promiscuity concerns?

3. Who do women/girls typically talk to about family planning?
    - What about communication within couples/partners related to family planning?
    - Do women believe they need permission from their sexual partner/husband to use or obtain family planning?

4. Are men (of your age) in your community generally supportive of or opposed to contraceptive use? Why?
    - How do men typically think about women's use of family planning?
        - Probe: Spacing pregnancies and births, limiting pregnancies and births, use of modern contraceptives, potential promiscuity of female partner, etc.
    - Are circumstances in which contraception is unacceptable for women?
        - If yes, what are those circumstances? Probes: Husband disagrees, not married, too young, side-effects/type of a method, religious reasons, etc.
    - What is the typical attitude of most men towards male condom use in this locality?

5. Is it considered socially appropriate for men and boys to support family planning and what are the social impact for men and boys engaging in more equitable gender behaviors?

6. Which contraception methods are couples in this community most likely to use? Why do couples prefer these methods?
    - Are husbands/male partners usually involved in decision making? If not, why?
    - What do you think should be done to increase male involvement?
      Probes: Are clinic hours accessible with men's availability? What about education and information materials (does it include men and boys?), Are males welcome to accompany their partner for family planning services?)

GBV Module

7. Have you heard about violence being perpetrated against women or girls in this community? *(Probe here on all different types of violence if they only list one or two types (physical, sexual, rape, emotional, VAC, FGM/C, IPV, forced/child marriage, etc.)*

    - What types of violence are typical/common?
    - Which groups are most at risk or vulnerable?
    - Who are usually the perpetrators (without mentioning or naming anyone)?

8. In this community, are there circumstances in which male use of violence against women/girls is viewed as an acceptable norm?

    - If yes, what are those circumstances and what types of violence are considered acceptable by the community?
    - In what situations are women blamed for the violence because of their behaviors or attitudes?

9. Why do you think some men in your community are violent toward women/girls, including their wives/partners?

    - What would the community members think about a man who is violent towards his wife/partner?

11. What is currently being done in this community to improve wellness of women and girls in relation to their sexual reproductive health and rights, including preventing the problem of GBV?

    - How has these efforts engaged men and boys?
        - What has worked well?
        - What challenges have you faced?
    - How could these efforts be improved? Specifically, what can:
        - Male leaders/groups do or be engaged?
        - How about husbands?
        - How about boys and youth leaders?

Concluding remarks

- Do you have any other thoughts that you would like to add, or a story/experience you haven't yet shared that you think is valuable?

- Thank you very much for your time and sharing your views. All information that was provided will remain strictly private and confidential to the study team.

Right Holders Cohort – FGD Guide

Version date: 27 May 2022

Session ID number: [_____]	Date of interview: [_____]
Start time of interview: [_____:_____]	End time of interview: [_____:_____]
County name: [_____]	Name of moderator: [_____]
Location of the meeting: [_____]	Number of participants: [_____]
Name of the group and group ID number: [_____]	Contact details of the group [_____]
Gender & age group of participants: [_____]	Audio available: Yes or No [_____]

Instructions: At each session, one of the modules will be administered, not both.

Module 1: SRH

Introduction: Read out

Hello, my name is _____. I am part of a research team conducting interviews on behalf of Population Services Kenya (PS Kenya). PS Kenya is a local NGO dedicated to improving health and saving lives.

Thank you all for coming here today and for agreeing to take part in this focus group discussion. As we mentioned, we are gathering information to learn from people of your age and gender around the issues of sexual reproductive health and rights in this community. Information gathered from this activity will be used to support health and wellbeing of women and girls in the community.

As we start this focus group, I would like to highlight a few important points.

- We encourage everyone to contribute freely to the discussions. All your opinions and perspectives are valuable to us.
- Participants should respect others even if they disagree. A participant who is verbally or physically aggressive or hostile towards (or threatens) another person in the meeting may be asked to leave the meeting.
- There is no judgement in this meeting in that there are no right or wrong answers. We are looking for your honest responses to our questions.
- We request you to speak one at a time so that we can hear what each of you is saying.

- We request that do not to refer to each other by real names, instead use your proxy or pseudo names throughout the session
- We request that we keep everything mentioned here today confidential. Do not divulge to others who are not here today about what we discussed.
- We emphasize that we will not directly ask or discuss participants personal encounter of violence or abuse. Instead, we encourage that you narrate experiences using examples without mentioning or naming anyone specifically.
- We have emphasized that every effort will be made to safeguard your responses from unauthorized access, all information that you will provide will remain strictly private and confidential to the study team. However, there are limits to confidentiality if an identifiable person makes a specific and time bound threat regarding a serious crime to an identifiable victim. We have a duty to report the case to the local chief, and the program staff to prevent the planned violence. To the prevent escalating the issue, the moderator will flash a stop sign should we feel the discussion is going in the wrong direction. We remind ourselves to refrain from threatening other people with violence or using examples that highlights specific people by names.
- We request to record the discussion for purposes of report writing
- The discussion will last approximately 60-90 minutes, slightly less or more
- Do you have any questions or comments before we start our conversation?
- Our discussion will start now

First, we will talk about what you know or heard about **family planning** in this community.

Local knowledge and perspectives about contraceptive use

10. What can couples do to control when to have children and how many children to have?

    - Which modern contraceptive methods do you know?
    - What method is **most common** in this community?
    - Which methods are available in the community?
    - Are some methods seen as **more appropriate** than others and why?

11. In this community or locality, is it typical for women to use a method of family planning (regardless of their age, duration/status of relationship, number of children)? Why?

    - Are there circumstances in which it is **unacceptable or viewed negatively** for women to use family planning and why?
        - Probes: Not married, too young, married but without children, partner's disapproval, promiscuity concerns, side-effects, type of a method, religious reasons, gender, economic and cultural norms, expectations of the number of children a family should have (example: more children may indicate may be viewed as a sign of prosperity)?

12. In your opinion, who do women/girls typically talk to about family planning/contraception?

    - Probes: Who in the family? Who among their peers? What about teachers? Health workers?
    - Whose advice on family planning/contraception is **most important** to them and why?

13. Do women typically believe they need **permission or approvals** from their sexual partner/husband to use or obtain family planning? Why?
    - Should women be able to use contraception **without** telling the partner and why? (Probe here for an explanation of their response).

14. Are people (of your age and gender) in this community/locality generally **supportive of or opposed** to contraceptive use? Why?

    - How do community members perceive/view family planning/ contraception?
        - Probe: Spacing pregnancies and births, limiting pregnancies and births, use of modern contraceptives, etc.
    - What are the local beliefs (if any) that influence the choice to **use or not use** contraceptives?
    - **If you or your wife (partner) is not** using any method at present, why do you think this is the case?

Reasons for unmet needs for contraceptive use

15. What are some things that make it hard for **women and girls** in your community/locality to get birth control if they want to prevent pregnancy?

    - Probe: barriers to access (e.g., distance to a provider, facility working hours); barriers to supply; inter-personal barriers with partner and family; social gender norms; out of pocket cost (e.g., transport to a provider)?
    - What reasons that would make women discontinue a modern method?
        - Probe: Religion and cultural beliefs, role of side effects, cost, limited access to health care (time and distance), supply shortages, inter-personal communication between couples (partner disapproval), lack of education/information, wanting to get pregnant?

Exploring sexual autonomy, and sexual violence among teenagers using a vignette

16. Now, I will narrate a story of a young adolescent girl called **{Sifa [use local name]}.** I would like you to imagine that **Sifa** is a typical girl living in this community. She is **15 years** old and lives with her parents and younger siblings. She is a pupil at a local primary school and goes to school most of the days just like her peers. However, her school is located far from home, thus she must trek for 45-60 minutes to get to school. Her parents are **{peasant farmers [use local economic activities]}** and do not have sufficient money to provide KSh 100 required for her daily transport. Recently, a local **{boda boda rider,** in **Garissa insert Tuk-Tuk/Alto driver}**. **{Brian [use local name]}** has been offering **Sifa** with free transport to school and occasionally offers her some money and buys her gifts. **Brian** is 28 years old, is unmarried and a well-known community member. On one of the days, **Brian** asked/demanded to have sexual intercourse with **Sifa**.

    - What would **most** adolescent girls, like **Sifa**, do in this situation?
        - Would they be able to say no unwanted sexual advances/sexual harassment? Why?

    - If she says no, would there be any repercussions, how would the man react?

- If she is forced to have sex, what would most adolescent girls do?
    - Would they be able to negotiate for safe sex (i.e., condom use)? How about other modes of contraceptive use?
    - Would they disclose/tell someone about being forced to have sex?
        - [If answer is 'nobody', then probe WHY?]
        - Who would they tell?
    - Would they seek medical care following forced sex?
    - Would they report the incident to local authorities (if there is a mechanism for this)? Why?

- If she disclosed forced sex to her parents, what would **most parents** do?
    - Would they seek justice, and from where?

Changing attitudes, behaviors, perceptions due to the SBC intervention?

8. Now I would like you to broadly think about the contraception situation in this community. Has the use of modern contraception in this community gotten worse, better, or stayed the same in the last 12 months? Explain why?

    - In the last 12 months, have you noticed any changes regarding awareness, perceptions, and attitudes of contraception among community members? What examples can you discuss that show this change?
        - Why do you think these have changed/not changed?
        - How about long terms methods such implants and IUD (Coil)? Why?
    - Why do you think those changes have occurred? or what led to those changes?
    - What else needs to occur to continue these changes in the future.

Concluding remarks

- Do you have any other thoughts that you would like to add, or a story/experience you haven't yet shared that you think is valuable?

- Thank you very much for your time and sharing your views. All information that was provided will remain strictly private and confidential to the study team.

- I would like to state as the official position of this project, we are bound by the Kenyan constitution which calls for respect for human rights, including access to health services for all, zero tolerance to all forms of violence including physical, emotional, and sexual, and harmful traditional practices such as wife beating, FGM/C, and early child marriages. We have a trained professional here today who can provide responses to your specific concerns, including care and support.

Module 2: GBV

Introduction: Read out

Hello, my name is _____. I am part of a research team conducting interviews on behalf of Population Services Kenya (PS Kenya). PS Kenya is a local NGO dedicated to improving health and saving lives.

Thank you all for coming here today and for agreeing to take part in this focus group discussion. As we mentioned, we are gathering information to learn from people of your age and gender around the issues of sexual reproductive health and rights in this community. Information gathered from this activity will be used to support health and wellbeing of women and girls in the community.

- As we start this focus group, I would like to highlight a few important points.
- We encourage everyone to contribute freely to the discussions. All your opinions and perspectives are valuable to us.
- Participants should respect others even if they disagree. A participant who is verbally or physically aggressive or hostile towards (or threatens) another person in the meeting may be asked to leave the meeting.
- There is no judgement in this meeting in that there are no right or wrong answers. We are looking for your honest responses to our questions.
- We request you to speak one at a time so that we can hear what each of you is saying.
- We request that do not to refer to each other by real names, instead use your proxy or pseudo names throughout the session
- We request that we keep everything mentioned here today confidential. Do not divulge to others who are not here today about what we discussed.
- We emphasize that we will not directly ask or discuss participants personal encounter of violence or abuse. Instead, we encourage that you narrate experiences using examples without mentioning or naming anyone specifically.
- We have emphasized that every effort will be made to safeguard your responses from unauthorized access, all information that you will provide will remain strictly private and confidential to the study team. However, there are limits to confidentiality if an identifiable person makes a specific and time bound threat regarding a serious crime to an identifiable victim. We have a duty to report the case to the local chief, and the program staff to prevent the planned violence. To the prevent escalating the issue, the moderator will flash a stop sign should we feel the discussion is going in the wrong direction. We remind ourselves to refrain from threatening other people with violence or using examples that highlights specific people by names.
- We request to record the discussion for purposes of report writing
- The discussion will last approximately 60-90 minutes, slightly less or more
- Do you have any questions or comments before we start our conversation?
- Our discussion will start now

First, we will talk about what you know or heard about violence against women and girls in this community.

Exploring types of GBV, perpetrators and community response against GBV

1. Have you heard about violence being perpetrated against women or girls in this community? *(Probe here on all different types of violence if they only list one or two types (physical, sexual, rape, emotional, VAC, FGM/C, IPV, forced/child marriage, etc.)*

    - What types of violence are **typical/common** in this community?
    - Which groups are **most** at risk? (Probe: Age, economic status, sex-workers), Why?
    - Usually, where and when (time of day) does most violence occur?
    - Who are the typical perpetrators (without mentioning or naming a specific individual)?
    - Why do you think girls/women in the community are perpetrated against?

2. In this community, are there circumstances in which male use of violence against women/girls is viewed as an acceptable norm?

    - If yes, what are those circumstances and what types of violence are considered **acceptable** by the community (probe why for each type of violence).
    - Are the instances in which women blamed for the violence because of their behaviors or attitudes? [probe, have them explain or provide examples]

3. When a husband/partner insists on sex from his wife/partner, does she have the right to refuse sex? Why?
    - If she does refuse and he forces her to have sex, from your opinion, does that constitute violence against women? Is that rape?

4. What does this community/locality (as a whole) do to prevent and to respond to violence against women and girls?
    - Probe for domestic violence /intimate partner violence, rape and defilement, FGM/C, forced and child marriages
    - Probe for activities by community – community groups, religious groups, elders, health workers, etc.
    - How are the survivors of sexual violence/gender-based violence re-integrated in the community?

5. What usually happens to suspected perpetrators of violence against women and girls? Please, provide examples without mentioning or naming anyone specifically.
    - How do female survivors or their families think about the justice systems? [probe for formal and informal systems]

Exploring GBV care seeking practices, and barriers

6. When women and girls are exposed to gender-based violence (physical, sexual, or emotional), what do they typically do?
    - Where do they **commonly** seek help and support. [Probe for specific places, and services provided]
    - Who do you think will be the right person(s) to help women/girls who are survivors of GBV? Why?
    - What would prevent them from seeking support, why?

7. Are there any situations in which it would **not be acceptable** for a woman or a girl to seek care or justice?
    - What are those situations and why?
8. Are there any barriers to reporting GBV and seeking services among women/girls in this community?
    - If yes, what are the **typical/common** barriers?
    - If not mentioned probe: *stigma, acceptance of violence as normal, logistical (cost, distance, hours of operation, etc.), lack of awareness of services, lack of trust in the benefits of services, lack of confidence in justice systems/corruption, lack of coordination between services, lack of follow up, or lack of the quality of services?*
    - If mentioned multiple barriers, please rank the 1st, 2nd, and 3rd commonest barriers.
9. What do you think needs to be done to break the most common barriers *(mention 1st, 2nd, and 3rd)* faced by women/girls when reporting or seeking post-GBV services?
    - Probe for gender norms in society, social cultural and religious barriers
    - Probe for reporting barriers [locally at the community level and more broadly at the judiciary system level]
    - Probe for accessing post-GBV services
10. Thinking about available services for GBV survivors in this community – including health services, justice services, etc. What would you say about the quality, comprehensiveness, affordability, and accessibility of these services? (Tackle one service at a time)
    - What are the gaps in the GBV services?
    - What other GBV programs or activities would you like to see in your community?
    - What do you think would be the best ways to prevent women and girls from experiencing violence from occurring in the first place?

Exploring perception and practices of intimate partner violence using a vignette

11. Now I will narrate a story of a typical family. **{Musa [use local name]}** is a 40-year-old man who lives in this community/locality with his wife **{Bahati [use local name]}** (28 years), and their 3 young children. Musa is a local businessman who sells second-hand clothes at a nearby market. His wife, **Bahati**,is a housewife and takes care of the children, family land and animals. One day, **Musa** quarrelled with his wife accusing her that she went out without telling him and that she had neglected their children. She started arguing with him, escalating the quarrel. Her actions angered **Musa** and he started shoving, slapping, kicking, hitting her with a stick, and holding her by throat and telling her he would beat her up more. As a result of the beating, her body was painful, face and limbs swollen, and she bled profusely from her injuries.
    - What would most married women, like **Bahati**, do or react if they were in this situation?
    - What would be the opinions and reactions of most men/males of your age (if they heard this story) and why?
        - What would they do if they were in this situation and why?

Exploring perception and practices of HTPs using a vignette [Ask in areas where child marriages, and FGM/C are common]

12. [**TO ASK in West Pokot and Narok**] Now I will tell you the story of a young adolescent girl called **{Sifa [use local name]}**. I would like you to imagine that **Sifa** is a typical girl living in this community/locality. She is **13** years old and lives with her parents and has two brothers. She is a pupil at a local primary school and goes to school most of the days just like her brother and peers. One day **Sifa's** parents tell her that they have been approached by **{Joshua [use local name]}** family in the community and would like their son to marry **Sifa**. **Sifa's aunt and grandmother** have suggested **Sifa** should undergo initiation (we mean cut) to prepare her for marriage. **Joshua** family is seen as respected members of the community as they are wealthy and influential in the community.

    - What would most adolescent girls, like **Sifa**, do in this situation? How would they react? [both to the idea of marriage and female circumcision/genital cutting]
    - If **Sifa**, refused, and chose to continue with her school:
        - Would this even be an option? Would she feel empowered enough to do this?
        - How would most parents of adolescent girls react? Why?
        - What would be the opinions and reactions of most adolescent girls? How would men and their family react if the adolescent girl like Sifa refused?
13. [**TO ASK in Garissa**] Now I will tell you the story of a young girl called **{Sifa [use local name]}**. I would like you to imagine that **Sifa** is a typical girl living in this community/locality. She is **6** years old and lives with her parents. She is a pupil at a local primary school and goes to school most of the days just like her peers. In recent times {Sifa's} grandmother and neighbours have been asking **Sifa's** mother if **sifa** is joining her peers to undergo female circumcision. A local ceremony is being organized by a group of women in the neighbourhood.

    - What would most families with going uncut girls, like **Sifa**, do in this situation? How would they react idea of female circumcision? Why?
    - If **Sifa's mother**, refused her to undergo female circumcision:
        - Would this even be an option? Would she feel empowered enough to do this?
        - What would be the opinions and reactions of most mothers with young girls?
        - How would men/boys react towards this decision?
        - What are men's/boys' attitudes toward uncircumcised girls/females in the community?

Changing attitudes, behaviors, perceptions due to the SBC intervention?

14. **[TO ASK in ALL Counties]** Now I would like you to broadly think about the situation of gender-based violence in this community. Has the problem of GBV in this community gotten worse, better, or stayed the same in the last 12 months?

    - What particular types of sexual violence have gotten worse, better, or stayed the same?
        - Why do you think these have changed/not changed?
    - Have you noticed any changes regarding awareness, perceptions, and attitudes of GBV among community members? What examples can you discuss that show this change?

15. **[TO ASK in West Pokot, Narok, Garissa**] In the last 12 months, are there changes that have you seen in the practice of female circumcision/female genital cutting?
    - Probe: stop cutting, reduce severity of cutting, younger age at cutting, medicalization, lack of ritual or public ceremony, other?
    - Why do you think those changes have occurred? or what led to those changes?
    - What else needs to occur to continue these changes in the future.

Concluding remarks:

- Do you have any other thoughts that you would like to add, or a story/experience you haven't yet shared that you think is valuable?

- Thank you very much for your time and sharing your views. All information that was provided will remain strictly private and confidential to the study team.

- I would like to state as the official position of this project, we are bound by the Kenyan constitution which calls for respect for human rights, including access to health services for all, zero tolerance to all forms of violence including physical, emotional, and sexual, and harmful traditional practices such as wife beating, FGM/C, and early child marriages. We have a trained professional here today who can provide responses to your specific concerns, including care and support.