Assessing the Efficacy Kenya of Community Health Strategy (KCHS 2020–2025) in Enhancing Women Reproductive Health in Pastoralist Communities

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DOI: https://dx.doi.org/10.47772/IJRISS.2025.907000420

Received: 14 July 2025; Accepted: 22 July 2025; Published: 21 August 2025

ABSTRACT

Pastoralist communities in Kenya face persistent reproductive health challenges due to a combination of geographical isolation, socio-cultural norms, and under-resourced healthcare systems. The Kenya Community Health Strategy (KCHS) 2020–2025 aims to improve primary healthcare access, with a specific focus on women of reproductive age (WRAs) in marginalized settings. This study assessed the effectiveness of KCHS strategies in enhancing reproductive health outcomes among WRAs in the pastoralist Kajiado County. A mixed-methods case study was employed, involving quantitative surveys with 272 WRAs and qualitative interviews with 45 community health actors and county-level officials. Quantitative data were analyzed using SPSS and qualitative data were processed using NVivo. Findings show that KCHS has made progress in reducing the burden on health facilities through deployment of Community Health Volunteers (CHVs), improving maternal awareness and care-seeking behavior. However, systemic challenges persist, notably in resource allocation, CHV motivation, accessibility, and data utilization. Reproductive health service utilization remains influenced by institutional, socio-economic, and cultural factors. The study concludes that while KCHS 2020–2025 has initiated positive change, a strengthened implementation framework is necessary to realize its full potential in pastoralist settings.

Keywords: Community Health Strategy, Reproductive Health, Pastoralist Communities, Women of Reproductive Age, Kajiado County

INTRODUCTION

Women's reproductive health remains a global public health concern, especially in marginalized communities where access to services is constrained. In Kenya's pastoralist regions, such as Kajiado County, cultural norms, low health infrastructure, and frequent migration patterns create unique barriers to care. These communities face elevated maternal morbidity and mortality, limited antenatal care (ANC) attendance, and low contraceptive uptake. Despite national and global commitments, including the Sustainable Development Goals (SDGs), disparities persist.

To address this, Kenya's Ministry of Health introduced the Kenya Community Health Strategy (KCHS) 2020–2025. It aims to enhance universal health coverage by promoting community-level health systems, particularly through the deployment of Community Health Volunteers (CHVs), improved supervision, and enhanced data use. While the strategy provides a framework for engaging underserved populations, its real-world impact, especially in pastoralist areas, requires evaluation.

This paper investigates the efficacy of KCHS 2020–2025 in improving reproductive health outcomes for women of reproductive age in Kajiado. It explores implementation status, access barriers, and contextual challenges facing community health systems in pastoralist context

METHODS

The study employed a case study design, focusing on Kajiado West Sub-County. A mixed-methods approach was used, combining both quantitative and qualitative data to gain a holistic understanding. Quantitative data were collected through structured household surveys with 272 women of reproductive age (WRAs) living near ten high-burden health facilities. Qualitative data were obtained from 45 respondents, including 33 Community Health Volunteers (CHVs), 12 Community Health Assistants (CHAs), the Sub-County Reproductive Health Coordinator, Community Health Strategy Focal Person, and Clinical Health Records Information Officer.

The study was guided by a conceptual framework adapted from Andersen's Behavioral Model and the Amooti-Kaguna & Nuwaha model, focusing on institutional, socio-economic, and cultural determinants of healthcare utilization. Quantitative data were analyzed using SPSS (descriptive statistics), while thematic analysis was conducted on qualitative responses using NVivo software.

Ethical approval for this study was obtained from the Maseno University Ethics Review Committee, Department of Health Kajiado County, NACOSTI research Permit. Informed consent was obtained from all participants prior to data collection. Participants were assured of confidentiality, anonymity, and their right to withdraw at any point without penalty. Data collected were securely stored and used solely for research purposes. No personal identifiers were recorded in the published report

RESULTS

The study found that reproductive health service utilization among women of reproductive age (WRAs) in Kajiado County is influenced by three broad categories of factors: institutional, socio-economic, and cultural.

Institutional factors such as the availability and accessibility of health facilities, quality of services, and healthcare workforce were critical. While the presence of Community Health Volunteers (CHVs) improved outreach and health awareness, challenges were noted in CHV training, supervision, and motivation many worked without adequate supplies or consistent remuneration. Health facilities frequently experienced stock-outs of reproductive health commodities and understaffing, impacting service delivery.

Socio-economic factors such as education level and household income significantly influenced service uptake. The findings of the study were that only 7% respondents had access to tertiary education, 26% No Formal Education,54% Primary Education ,13% Secondary Education respectively. Women with secondary or higher education were more likely to attend antenatal clinics, deliver in health facilities, and access family planning services. With only 1% of respondents being employed, 2% in business while 88% are home markers, financial barriers, especially the cost of transportation to distant health facilities, emerged as a major constraint. The insights from Community health Volunteers revealed marriage context of Kajiado is often approached from a utilitarian perspective, primarily centered on procreation and survival. This pragmatic outlook emphasizes the needs of the household over the individual well-being of women, particularly with regard to their sexual and reproductive health. Traditional gender expectations and the pressures of economic necessity frequently take precedence over women's autonomy, sexual rights, and holistic health. Consequently, women's reproductive choices and overall well-being are often overlooked, with cultural norms reinforcing their role as child bearers and caretakers

Cultural factors played a substantial role. Deep-rooted gender norms, traditional beliefs, and male-dominated decision-making limited women's autonomy in seeking care. Practices such as early marriage and reliance on traditional birth attendants (TBAs) were prevalent, hindering the uptake of modern reproductive health services. Despite health education efforts, misconceptions about contraception and institutional delivery remained common. A striking finding reveals that an overwhelming 89% of women of reproductive age (WRAs) report that they are never involved in making household decisions. This alarming statistic underscores the deep-rooted gender inequalities that persist within these communities, significantly constraining women's agency and autonomy in their own homes. The lack of participation in household decisions not only affects their immediate environment but also limits their ability to influence broader community issues that impact their lives and health.

Qualitative data collected from Key Informant Interviews (KII) with Community Health Assistants (CHAs) and In-Depth Interviews (IDI) with Community Health Volunteers (CHVs) further elucidate these disparities, particularly within the Maasai community. Cultural norms dictate that women are to be seen but not heard, which reinforces their marginalization. This cultural expectation equates women with children, subjecting them to various restrictions that impede their full participation in household and community life. For instance, women are often prohibited from eating at the men's table, and corporal punishment, such as caning, is employed as a means of discipline. Such cultural practices vividly illustrate the profound barriers women face in their quest for equality and autonomy. Consequently, many women find themselves suppressing their personal needs, including those related to sexual and reproductive health, simply to maintain peace and coexistence with their husbands. Beyond physical violence, the KDHS 2022 data highlights the prevalence of sexual violence in Kajiado, revealing that 17% of women have experienced sexual violence at some point in their lives, with 9% reporting such experiences within the past 12 months. These statistics reflect not only the physical and emotional toll on women but also the power imbalances and socio-cultural dynamics that perpetuate gender-based violence

The implementation of KCHS 2020–2025 showed mixed results. While community-level awareness and engagement improved, many community health units (CHUs) were non-functional or underperforming. Data collection remained largely manual, affecting reporting accuracy and health planning at sub-county levels. The Subcounty MoH who doubles as the reproductive health coordinator, pointed out that reliance on external partners (NGOs) has resulted in uneven training opportunities, leaving gaps in skills and knowledge that are crucial for effective community health services.

DISCUSSION

The findings of this study underscore that while the Kenya Community Health Strategy (KCHS) 2020–2025 provides a comprehensive framework for improving community health, its implementation in pastoralist settings like Kajiado is significantly limited by systemic and contextual challenges. Chief among these is high population mobility, entrenched cultural norms, infrastructural deficits, and insufficient financial investment. In pastoralist regions like Kajiado, communities are often on the move, migrating regularly in search of water and pasture for their animals. This lifestyle makes it difficult to maintain steady community health structures like Community Health Committees (CHCs) and Community Health Units (CHUs). These structures depend on people staying in one place to ensure ongoing training, supervision, and data collection of all key parts of the KCHS system (Ngugi et al., 2021).

Another challenge is the low level of literacy in many pastoralist areas. In places like Kajiado and many pastoralists' context, Community Health workforce mainly CHCs, CHVs and CHAs are usually chosen based on their popularity or local respect rather than education or technical skills. Because of this, many struggle to understand written policies, use health data, or complete reports properly. This affects planning, accountability, and the overall effectiveness of community health governance. Cultural beliefs also play a big role. In some pastoralist communities, traditional views on reproductive health, maternal care, and family planning make people especially women less likely to use formal health services. Many CHC members, who are part of the same culture, may not feel confident or willing to challenge these beliefs. This makes it harder to bring about positive behavior change and improve reproductive health outcomes (KNBS & ICF, 2022). Pastoralist areas also face financial challenges. Often, county and national governments do not allocate enough money or resources to support health governance in these regions. The Kenya Community Health Strategy depends heavily on counties to provide funding and oversight, but in Kajiado and similar areas, health structures often remain weak due to poor support. As a result, CHCs and Community Health Volunteers (CHVs) are not able to do their work properly.

This raises a critical question: is the KCHS 2020–2025 properly adapted to the realities of pastoralist areas? According to the findings of this study, while the KCHS 2020–2025 is well-structured on paper, it is not designed with the needs of nomadic communities in mind. For example, the strategy assumes communities are settled and can consistently participate in health activities. But in places like Kajiado, where families move often, CHC members frequently change, weakening the system and creating gaps in memory and leadership.

The KCHS 2020–2025 also focuses on building skills, setting clear roles, and encouraging accountability for CHCs. However, the tools and processes used require reading and writing skills that many respected local leaders

do not have. This means that although these individuals are trusted and knowledgeable about local health issues, they struggle to understand policy documents or engage with health officials, reducing their ability to lead effectively. In Kajiado, the Community Health Workforce also receive little to no incentives. Without financial support or recognition, many members lose interest in their roles. Selection processes are also flawed, as some members are chosen based on politics or popularity instead of their ability to lead or plan, which reduces the quality of governance and passion for the job.

The KCHS 2020–2025 does not fully address cultural beliefs that affect health decisions either. In many pastoralist communities, beliefs around childbirth, family planning, and maternal care continue to guide how people behave an example cited during FGD is that home delivery is approve that women are healthy and strong. CHCs often avoid challenging these beliefs, which leaves women of reproductive age at a disadvantage and risk. The strategy does not provide enough training or support to help health workers address these deep-rooted norms.

On top of all this, county governments often fail to give enough money or support to implement the strategy properly. In places like Kajiado, training, supervision, and performance tracking are often neglected due to limited resources and shifting priorities. This creates a gap between what the strategy promises and what actually happens on the ground. The study also found that the second objective of the KCHS; creating a skilled and motivated community health workforce is not working well in pastoralist areas. CHVs in Kajiado are supposed to get a monthly allowance of KES 2,000, but these payments have not been made. Training and supervision rely heavily on NGOs like World Relief and Amref Health Africa, and areas like Oloika, Torosei, and Pakase are often left out due to remoteness and lack of resources. The strategy also assumes that CHVs will remain in one location for a long time. However, because families move frequently, CHVs often leave, and new ones need to be trained. This causes delays, increases costs, and makes service delivery less effective. The strategy promises career growth opportunities for CHVs and their supervisors (CHAs and CHOs), but in reality, many workers don't understand how to advance. This lack of motivation leads many to leave for better-paying jobs in NGOs, weakening public health services. Pastoralist areas also face environmental and infrastructure challenges that the KCHS doesn't fully address. Poor roads, harsh weather, and long distances between homes make it difficult for CHVs to reach families regularly. Since women often face restrictions in movement, CHVs are crucial in providing health information and services. Yet, the study shows that CHVs are not properly trained or supported to handle cultural issues or build trust among women. Reproductive health programs rely heavily on the work of CHVs, but when these workers are poorly trained, unpaid, or overburdened, the services fail. Past issues with the 2014–2019 KCHS still exist today many counties did not fully fund their health activities, and this continues under the current strategy. Even though Kajiado passed the Community Health Services Bill, it is not being fully implemented, especially in areas like stipend payments and budget allocation.

The study also shows that the third objective of the KCHS (2020-2025) to increase sustainable funding for community health is not working well in pastoralist settings. The strategy recommends new financing approaches like updated investment plans, higher county health budgets, and integrating community health into insurance. But these ideas don't match the financial reality in places like Kajiado and many more pastoralist contexts. Health facilities in Kajiado and many other pastoralist contexts lack basic services like clean water, which limits what can be done. A significant percentage of community health activities are funded by donors. When organizations like AMREF and World Relief leave, Community health services significantly suffer because there's no county funding to replace them. This makes the system weak and unpredictable. It is also more expensive to provide health services in nomadic areas due to bad roads, long distances, and frequent movement. The KCHS (2020-2025) does not fully consider these extra costs. It assumes a one-size-fits- all approach that doesn't work in places where mobile services and flexible staffing are needed. Most ASAL counties also struggle to raise their own money because of limited business activity and pressing needs like hunger and poverty. This means reproductive and preventive health services are often ignored in Favor of more visible projects. Women of reproductive age are the most affected by these funding problems. Many cannot afford to pay for services, and without donor help, they go without care, increasing risks to maternal and child health.

Another goals of the Kenya Community Health Strategy (KCHS) 2020–2025 also is to improve how community health services are delivered by making them more integrated, complete, and of high quality. Although this is a good plan, it does not fit well with the real situation in pastoralist areas like Kajiado. These regions face many

challenges, such as people moving from place to place, poor roads and infrastructure, and weaknesses in the health system, all of which make it hard to fully carry out the strategy. A big part of this goal is the work done by Level 1 health facilities and Community Health Volunteers (CHVs). These health workers are supposed to provide health education, prevent illness, treat small health problems, and help refer patients to bigger health facilities. The Qualitative data from Subcounty health officials as well as CHVs revealed that in Kajiado West, the referral system does not work well. CHVs often meet resistance from health facility staff when they refer patients. Nurses sometimes ignore referral forms from CHVs and do not sign them, which discourages follow-up and weakens the whole process. There is also no standard referral form being used across the area. The Ministry of Health's MoH 100 booklet is not always available, and the digital system for referrals is slow to roll out because most CHVs don't have smartphones or training to use them. These problems especially affect women of reproductive age (WRAs), who need timely services like antenatal care, family planning, and help during childbirth. The strategy talks about giving CHVs more training and support to help them do their jobs better. But in Kajiado, training is not consistent. Most of it is done by donors or NGOs such as Amref Health Africa and World Relief. These trainings only reach certain areas and are linked to short-term projects. Because of this, many CHVs do not have the full set of skills needed, especially in important areas like reproductive health education, helping teenagers with sexual health, and providing family planning. This is a big issue because CHVs are often the only health workers available in remote communities (Sub-County MoH, 2023).

Also as revealed by Sub-County Moh, who doubles as Reproductive Health coordinator, CHVs do not always have the supplies they need to do their work. Their kits often miss important items, and family planning products are regularly out of stock. As a result, they have to refer women to health facilities for services that could be done at the community level. This puts more pressure on the weak referral system and makes it harder for women to get the care they need. The situation is made worse by the environment and way of life in pastoralist areas. Long distances, seasonal movement of people and animals, and poor roads make it hard for CHVs to get supervision, training, or supplies regularly. Women of reproductive age who depend on CHVs are left with limited support because community health services are not strong or reliable in these areas. This matches earlier findings from KIPPRA during the review of the previous health strategy (KCHS 2014–2019). That study found that lack of supervision, not enough training, and poor connection between community and health facility services were common problems in pastoralist regions (KIPPRA, 2020). Unfortunately, these issues are still present in the current strategy

The other goals of the Kenya Community Health Strategy (KCHS) 2020–2025 is to "increase the availability, quality, demand, and use of data" to improve how health services are delivered. While this goal is important, it has not worked well in pastoralist areas like Kajiado. This is because the culture, way of life, and geography in these regions make it hard to use data systems effectively (Ministry of Health, 2020). Past experiences, including the KCHS 2014–2019, showed that managing health data at the community level has always been a challenge. A report by the Kenya Institute for Public Policy Research and Analysis (KIPPRA) found that few people used the community health information system, and it was not well linked to the national District Health Information System (DHIS). These same problems continue in the 2020–2025 plan, especially in places like Kajiado where systems to collect and manage data are still weak. As a result, the health data is often missing, incorrect, or late.

In Kajiado West, KII with the subcounty CHIRO revealed that community health units are not well connected, and there are no proper systems to give feedback on data collected. This leads to poor-quality data, especially about reproductive health, such as antenatal care (ANC), postnatal care (PNC), family planning, and follow-up of patients who miss services at the community level. The problem is made worse because the Community health worker force still use paper-based tools and often don't have the materials they need always. This makes it hard for them to collect and report data properly. Without good data, it is difficult to design health services that meet the needs of mobile communities in pastoralist areas. Although the KCHS 2020–2025 promotes using digital tools like the electronic Community Health Information System (eCHIS) and training Community Health Volunteers (CHVs) to use these tools, this has not been fully put into action. Interviews and focused group discussions from the study showed that many planned activities, such as updating CHV training manuals and giving out digital tools, have not been completed. This is mostly because the county government depends too much on donors for funding. This situation shows a bigger problem data systems are not built to last unless they are fully supported by the local health system. Another major issue is the lack of real-time and location-specific data. This kind of data would help health officials understand when and where nomadic groups are likely to be,

so that mobile clinics or temporary health services can be provided at the right time. But without this information, health services remain fixed and general, and they don't fit the actual needs of people in pastoralist areas.

This gap between what the KCHS plans to do and what is really happening in marginalized contexts creates a negative cycle. Poor data leads to weak health services, and weak health services lead to poor health outcomes especially for women of reproductive age who already have trouble getting care. Without good data, it is also hard to measure what is working and make improvements. This reduces the overall success of the strategy in marginalized areas.

While the Kenya Community Health Strategy (KCHS) 2020–2025 outlines progressive measures to ensure the availability and rational distribution of high-quality health commodities, its implementation is ill-suited for pastoralist settings such as Kajiado West due to systemic and contextual barriers. One of the core objectives of the strategy is to secure a reliable supply of essential commodities, particularly for women of reproductive age (WRAs). However, the ground reality in marginalized regions reveals a substantial mismatch between policy aspirations and practical delivery mechanisms. A key issue lies in the inadequate distribution and management of reproductive health commodities, despite the introduction of CHV kits and management guidelines. According to qualitative insights from Key Informant Interviews (KIIs) with sub-county reproductive health coordinators and community health focal persons in Kajiado West, CHVs still face persistent stockouts and lack the capacity to manage supplies efficiently. This includes deficits in forecasting, quantification, and logistical distribution, all of which are critical for sustaining service delivery in remote and mobile populations. Although the strategy proposes to integrate digital tools and strengthen Logistics Management Information Systems, the limited digital literacy and poor infrastructure in pastoralist settings pose serious barriers. These regions often lack stable internet connectivity, and CHVs rarely receive consistent, targeted training in digital commodity tracking and forecasting. Without this foundational capacity, the use of digital platforms remains aspirational rather than achievable in practice. Moreover, despite the policy's ambition to empower CHVs as frontline providers, their kits often arrive incomplete or without key reproductive health commodities such as contraceptives, antenatal and postnatal care items. This directly affects women in these communities who due to cultural norms and logistical barriers rely primarily on CHVs for care. The failure to equip CHVs adequately diminishes trust in community health services and compromises the broader goal of improving maternal health outcomes in underserved regions (KIPPRA, 2020).Evidence from previous evaluations, such as the KIPPRA assessment of the 2014–2019 strategy, also highlighted that only 53% of counties had budgetary provisions for community health commodities, revealing chronic underfunding and weak supply chains (KIPPRA, 2020). Although KCHS 2020–2025 attempts to address this with national alignment, training modules, and updated guidelines, these interventions fail to account for the unique geographic, cultural, and logistical challenges of pastoralist regions like Kajiado West. The success of a community-based health strategy in pastoralist areas requires more than national-level planning. It demands context-specific interventions, decentralized forecasting systems, on-the-ground logistical support, and continuous training tailored to local realities. The current approach of the KCHS 2020–2025 lacks the granularity and adaptability needed to function effectively in fluid, semi-nomadic, and infrastructure-poor environments, making it ill-equipped to address the nuanced healthcare needs of Kajiado West and similar pastoralist communities

The strategy's final objective "Creating a Platform for Strategic Partnership and Accountability" rightly recognizes the fragmentation of the community health system and proposes mechanisms to consolidate partner efforts across public and private sectors (Ministry of Health, 2020). However, this framework appears ill-suited for marginalized pastoralists socio-economic and geographic context, where resource constraints and competing survival priorities significantly undermine its implementation.

Firstly, resource limitations remain a major hindrance. As noted in the research, proposals under the KCHS such as stakeholder mapping, partnership frameworks, and quarterly coordination forums have been scaled back or delayed in counties like Kajiado due to acute shortages in health infrastructure, workforce, and financing. These challenges are exacerbated in pastoralist areas by widespread poverty, food insecurity, and endemic diseases, which force communities and local governments to prioritize basic survival over long-term system reforms. Consequently, while the strategy calls for strong engagement and coordination among partners, the capacity to facilitate and sustain such partnerships is glaringly absent in these marginalized regions. Moreover, while the strategy advocates cross-sectoral synergies such as leveraging schools for health promotion or integrating

agriculture and nutrition into maternal health these assumptions rest on the existence of a robust public service ecosystem, which is often non-existent or weak in pastoralist areas. Many schools in Kajiado, for instance, face infrastructure deficits, teacher shortages, and irregular attendance due to migratory lifestyles. This makes them unreliable as platforms for health interventions. Similarly, the idea of harnessing private sector partnerships presumes an active local market, yet in vast rural zones of Kajiado, market systems remain underdeveloped, limiting the practical application of private-sector-led health solutions.

Additionally, the geographic mobility and cultural practices of pastoralist communities which are rarely addressed directly in the strategy create a mismatch between national frameworks and local realities. For instance, quarterly stakeholder engagement meetings, a key accountability mechanism in strategy, are difficult to execute in regions where communities are constantly on the move in search of pasture and water. This mobility makes it difficult to ensure continuity in health service delivery, community engagement, and data tracking factors that are central to the KCHS implementation model. Furthermore, although the KCHS acknowledges the importance of gender-sensitive community health structures, it does not fully consider how deep-rooted cultural barriers, particularly around issues like adolescent reproductive health, early marriage, and menstrual health, limit the uptake of these services in pastoralist communities. As the CHS focal person revealed, promoting school retention for girls is key to improving reproductive health outcomes. However, this requires more than health and education alignment; it demands context-specific behavioral change strategies and long-term community engagement, which the current strategy does not adequately provide.

CONCLUSION

while the KCHS 2020–2025 is well-intentioned and has demonstrated progress in stakeholder mapping and awareness building, its strategic objectives and implementation mechanisms are largely designed for static, well-resourced, and institutionally stable environments. Pastoralist regions like Kajiado, with their fluid settlement patterns, systemic resource constraints, and entrenched socio-cultural barriers, require a more localized and adaptive approach. Without tailored strategies that reflect the lived realities of these communities, the vision of inclusive, equitable community health envisioned in the KCHS risks leaving behind the very populations it aims to serve. To improve reproductive health outcomes in marginalized regions, the KCHS must be adapted to local realities. This includes adopting mobile health models, providing culturally appropriate education, investing in CHV capacity and motivation, and developing context-specific financing and data solutions. Without such localized, flexible interventions, the strategy risks failing the very populations it seeks to serve.

RECOMENDATION

Having discussed the key shortcomings of the Kenya Community Health Strategy (KCHS) 2020–2025, particularly in relation to its implementation in pastoralist contexts, the following recommendations are proposed to enhance its effectiveness and inclusivity:

Addressing Institutional Challenges through Improved Healthcare Accessibility. To overcome institutional barriers, it is essential to expand and decentralize healthcare infrastructure by increasing the number of health facilities, especially in underserved and mobile pastoralist regions. These facilities must be strategically located and designed to accommodate the migratory patterns of pastoralist communities. Beyond infrastructure, emphasis should be placed on improving the quality of care through the consistent availability of skilled healthcare personnel and the provision of culturally competent, patient-centered services. Additionally, sustained investment in the capacity building of healthcare professionals including Community Health Volunteers (CHVs) is critical. CHVs should be equipped to provide promotive and preventive care at the household level, especially for women of reproductive age.

Tackling Cultural Barriers through Contextual Health Education and Community Engagement. Cultural beliefs and practices that hinder reproductive health service uptake must be addressed through locally relevant, low-literacy health education campaigns. These programs should be tailored to challenge harmful traditional practices such as Female Genital Mutilation (FGM), early marriage, and reliance on Traditional Birth Attendants (TBAs) which negatively influence health-seeking behavior among pastoralist women. Engaging and empowering cultural and religious leaders as reproductive health champions is vital. Their influence can help shift community norms and foster more positive attitudes toward modern reproductive health services.

Responding to Socio-Economic Barriers through Financial and Economic Empowerment Initiatives. Socio-economic constraints that limit women's access to reproductive health services can be mitigated by introducing targeted financial support mechanisms. These may include reproductive health vouchers, transport subsidies, or conditional cash transfers for maternal and child health. Simultaneously, integrating women's economic empowerment initiatives such as livelihood programs and access to microfinance can increase household income and, in turn, improve women's ability to independently seek and afford healthcare services.

Strengthening KCHS Implementation with a Focus on Marginalized and Mobile Populations. For the KCHS 2020–2025 to achieve equitable impact, its implementation must be strengthened and adapted to suit the dynamic realities of pastoralist and transitory populations. This includes designing flexible service delivery models such as mobile clinics, deploying satellite health teams, and integrating reproductive health services into broader community development programs. Moreover, county governments must allocate adequate resources for training, supervision, data systems, and the provision of health commodities, ensuring continuity and sustainability of services beyond donor support.

Finaly, a more inclusive, context-responsive approach is essential for realizing the full potential of the KCHS 2020–2025. Only through deliberate, targeted interventions can reproductive health equity be achieved for all women, regardless of geography, cultural background, or socio-economic status.

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Conflict of Interest: The authors declare no conflict of interest.

Funding Statement: This research was conducted without external funding.

Ethical Approval: Ethical approval was obtained from the Maseno University Ethics Review Committee, the Department of Health – Kajiado County, and NACOSTI