

**MINISTRY OF HEALTH**

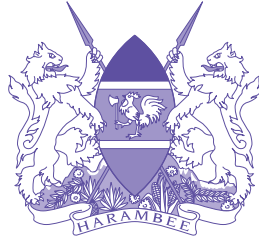


**Republic of Kenya**

**NATIONAL REPRODUCTIVE HEALTH POLICY**

**ENHANCING REPRODUCTIVE HEALTH  
STATUS FOR ALL KENYANS**

October 2007



Republic of Kenya

# **NATIONAL REPRODUCTIVE HEALTH POLICY**

## **ENHANCING REPRODUCTIVE HEALTH STATUS FOR ALL KENYANS**

October 2007

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## **FOREWORD**

Reproductive health programmes contribute to the realisation of the Millennium Development Goals, which aim to improve maternal health, reduce neonatal and child mortality, reduce the spread of HIV/AIDS and promote women's empowerment and gender equality. The International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994 called for the development of comprehensive reproductive health policies, programmes and implementation plans emphasising the strategic roles of information, education and community mobilisation and participation.

The second National Health Sector Strategic Plan (NHSSP II 2005–2010), appropriately themed “Reversing the trends,” represents a paradigm and policy shift emphasising preventive rather than curative services. It focuses on service delivery to a wider public and the promotion of healthy lifestyles of individuals and communities. The NHSSP II is being operationalised through the delivery of a minimum package of services, commonly referred to as the Kenya Essential Package for Health (KEPH). Reproductive health is a core component of KEPH.

Presently, reproductive health services are provided as stipulated in the National Reproductive Health Strategy, 1997-2010. However, there is need for a policy framework providing for equitable, efficient and effective delivery of quality reproductive health services. This policy fills that gap, which is in line with the provisions of the Kenya Health Policy Framework (KHPF) of 1994 and the NHSSP II of 2005- 2010.

It is the policy of the Government to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services and by improving quality, efficiency and effectiveness of services provided at all levels.



This policy is guided by certain principles, among them respect for human rights and freedoms. All couples and individuals have the basic right to decide freely and responsibly the timing, number and spacing of their children and to have access to information and education they require to make informed decisions. All people should decide freely and responsibly on all aspects of their sexuality, including the right to be free from conditions that interfere with their sexual health, including harmful practices, sexually acquired infections, complications associated with menopause and andropause, and coercion into sexual acts and other forms of sexual violence.

This policy will guide the provision of high quality reproductive health services countrywide, especially to those in greatest need and most vulnerable. This will fast track our efforts towards realisation of the health-related Millennium Development Goals and ICPD goals.

A handwritten signature in blue ink, appearing to read 'Ngilu', is centered on the page. The signature is fluid and cursive, with a large initial 'N'.

**Hon. Charity K. Ngilu, M.P.**  
**Minister for Health**

## **ABBREVIATIONS**

AIDS	Acquired Immuno-Deficiency Syndrome
ARH&D	Adolescent Reproductive Health and Development
ARV	Anti-retrovirals
ARVT	Anti-retroviral Therapy
CBOs	Community-Based organisations
CPR	Contraceptive Prevalence Rate
CORPs	Community-owned Resource Persons
CSO	Civil Society Organisations
DHMTs	District Health Management Teams
DRH	Division of Reproductive Health
ERSWEC	Economic Recovery Strategy for Wealth and Employment Creation
FBO	Faith-Based Organisation
FGC	Female Genital Cutting
FP	Family Planning
GDP	Gross Domestic Product
GoK	Government of Kenya
HFC	Health Facility Committee
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSRP	Health Sector Reform Programme
HSV	Herpes Simplex Virus
ICPD	International Conference on Population and Development
JICC	Joint Interagency Coordinating Committee
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
KHPF	Kenya Health Policy Framework
KMTC	Kenya Medical Training College
KSPA	Kenya Service Provision Assessment
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals

MoH	Ministry of Health
NASCOP	National AIDS and STD Control Programme
NCAPD	National Coordinating Agency for Population and Development
NGO	Non-Governmental Organisation
NHSSP	National Health Sector Strategic Plan
NPPSD	National Population Policy for Sustainable Development
NSHIF	National Social Health Insurance Fund
OVC	Orphans and Vulnerable Children
PHMT	Provincial Health Management Team
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of mother to child transmission
RH	Reproductive Health
RH-ICC	Reproductive Health Inter-agency Coordinating Committee
RHT&S	Reproductive Health Training and Supervision
RTIs	Reproductive Tract Infections
STIs	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate
UNCRC	United Nations Convention on Rights of Children
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WSSD	World Summit on Sustainable Development

# I. PREAMBLE

This National Reproductive Health Policy aims to guide planning, standardisation, implementation, and monitoring and evaluation of reproductive health (RH) services provided by the Government, non-governmental organisations (NGOs), faith based organisations (FBOs), community based organizations (CBOs), private-for profit sectors, and communities in Kenya. The policy elaborates on the relevant provisions of the Kenya Health Policy Framework (KHPF) of 1994, which aimed “to promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable”.

The goal of this policy is to improve reproductive health state of all people in Kenya by increasing equitable access and improving quality, efficiency and effectiveness of service delivery at all levels. Reproductive health rights are critical in realising the goal, objectives and targets of Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development (NPPSD). The National Reproductive Health Strategy, 1997-2010, has been guiding implementation of the reproductive health programme, but has faced a number of challenges, especially inadequate funding. This has led to the deterioration in the quality of health service delivery, resulting in negative health indicators. The National Reproductive Health Policy will provide a framework for the review and revision of the strategy towards addressing these challenges effectively.

Kenya is a signatory to the Programme of Action of the International Conference on Population and Development (ICPD) of 1994, and the Millennium Development Goals (MDGs) approved by the World Summit on Sustainable Development (WSSD) in September 2000. The National Reproductive Health Policy outlines priority actions for improving maternal health, reducing neonatal and child mortality, reducing the spread of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and achieving women’s empowerment and gender equality. Respect of sexual and reproductive health rights, within the context of the law, should make a positive

impact to the reduction of infant and maternal mortality and HIV/AIDS incidence. A key challenge to attainment of the MDGs is inadequate capacity to manage health programmes, especially shortage of skilled health workers, inadequate budgetary provision and poor procurement and supply systems, among other critical management problems. New and far-reaching reforms in the health sector contained in the Second National Health Sector Strategic Plan of 2005-2010 (NHSSP II), provide a framework for addressing the challenges in this National Reproductive Health Policy.

Implementation of the full range of the reproductive health components requires a collaborative, multi-sectoral approach. Further, the NHSSP II recognises that 'reversing the trends' cannot be achieved by the government health sector alone. A well-functioning health system must have strong partnerships with non-governmental stakeholders, that are accountable to both government and consumers, and who follow and contribute to the agreed national norms and standards. Thus, fostering good partnerships, especially among development partners, key line ministries, communities, CBOs, NGOs, FBOs and the private-for-profit sectors, is recognised as the main vehicle for effective implementation of this policy.

## 2. PRINCIPLES

The following principles guided the development of the National Reproductive Health Policy, and should guide its implementation:

- a) Human rights and freedoms must be respected by all, regardless of religion, culture and socio-economic status. Reproductive and sexual health rights, within the context of the law, are components of human rights, should be observed and adhered to by service providers who should recognise that:
  - i) all couples and individuals have the basic right to decide freely and responsibly the timing, number and spacing of their children, have access to information and education in order to ensure optimal health and informed decision-making.
  - ii) all people have the right to decide freely and responsibly on all aspects of their sexuality, and have the right to be free from conditions that interfere with sexual health such as harmful practices; sexually acquired conditions including sexually transmitted infections (STIs) and HIV/AIDS; complications associated with menopause and andropause; and coercion into having sex and other forms of sexual violence.
- b) Reproductive health care must be responsive to expressed needs of the consumers. Individuals and/or communities, have both rights and responsibilities in promoting their own health and development. Mechanisms to achieve consumer participation in decision-making, planning, implementation, monitoring and evaluation (M&E) of reproductive health programmes (Health Committees, Health Boards, etc.) must be available to consumers.
- c) Failure to prevent maternal and newborn deaths is a social injustice that violates human rights. In this respect, RH providers must endeavour to eliminate factors that impede equitable access to RH services and in particular the reduction of financial, social, political and cultural barriers



to those seeking reproductive health information and services, especially among the more vulnerable members of the population.

These include, but are not limited to:

- i) People with disabilities;
  - ii) People infected or affected by HIV/AIDS;
  - iii) Orphans and vulnerable children (OVC), homeless, refugees and abused persons;
  - iv) Youth and adolescents, including single parents;
  - v) The poor in urban, rural and hard to reach areas;
  - vi) Elderly persons; and
  - vii) Infertile couples.
- d) Reproductive health and HIV/AIDS services have certain advantages if planned and provided in an integrated way and to mutual advantage.
- e) Provision of reproductive health services are enhanced by policies and programmes that promote gender equity and equality, empower women and eliminate all forms of gender-based violence and related harmful practices. Gender equity and equality must be addressed at all levels of service delivery, including information and M&E. Involvement of men as RH consumers and responsible partners to women will increase access to and use of RH services, including STI prevention and treatment services by both women and men.
- f) There are many providers of reproductive health services besides the Ministry of Health (MoH) and its agencies. These include other government ministries, NGOs, FBOs, for-profit private sector organisations, CSOs and communities, all of which have expanded access to RH information and services.
- g) The Ministry of Health through the Division of Reproductive Health (DRH) has stewardship of the national reproductive health programme. Consequently, all RH providers are required to operate according to the national RH Strategic Plan and all norms and standards set by the MoH,

within the spirit of these principles.

- h) Implementation of this policy should be guided by adoption of evidence-based practices, a human rights approach, quality improvement, standard setting and audit, and application of appropriate and cost-effective technologies.



## 3. REPRODUCTIVE HEALTH POLICY FRAMEWORK

### 3.1 Introduction

#### 3.1.1 Social and Economic Setting

Kenya is a multi-ethnic and multi-cultural society. Approximately 88 per cent of the land is arid or semi-arid, while the remaining 12 per cent has high potential for agricultural production. During the 1960s and 1970s the Kenyan economy grew by about 7 per cent per annum. Thereafter, there was a consistent decline in economic growth, reaching the lowest gross domestic product (GDP) growth rate of -0.3 per cent in 2000. The poor growth of the economy contributed to an increase in poverty levels leading to deterioration in the health status and overall welfare of the Kenyan population. It is estimated that 56 per cent of the population live in poverty<sup>1</sup>. However, beginning in 2003, the economic growth rate has improved and was estimated at 4.9 per cent in 2004 and 5.9 per cent in 2005. In 2003, the government launched the Economic Recovery Strategy for Wealth and Employment Creation (ERSWEC) with the goal of poverty reduction. The ERSWEC (2003-2007) and the National Development Plan, 2004-2009 together present the road map for economic recovery.

#### 3.1.2 Demographic Setting

The population of Kenya was estimated at 33.4 million in 2005 and is projected to reach 39.7 million in 2015. The population is generally youthful with the proportions of those under five years and under 15 years being 15 per cent and 44 per cent, respectively, of the total population of the country. Women of reproductive age (15-49 years) were estimated at 8.6 million in 2005, constituting about 26 per cent of the total population, while the proportion of those aged 65 years and above was about 4 per cent (1.3 million). Life expectancy at birth, which had reached 59 years in 1989, declined to 57 years in 1999 due to AIDS and is expected to decline further to about 53 years in the

1. CBS (1999). *National Poverty Eradication Plan*, Nairobi: Government Press.

2015-2020 period. Total fertility rate (TFR), which was estimated at 4.9 live births per woman in the period 1998–2005, is not expected to fall below 3 live births per woman by 2015. At the same time, mortality levels are expected to rise slightly in the future after a long period of decline due to the AIDS pandemic. Both infant and under five mortality rates have increased from 74 and 112 per thousand, respectively, in 1998 to 77 and 115 per thousand, respectively, in 2003. However, the maternal mortality ratio has remained high at over 400 per 100,000 live births since 1998, but with wide regional variations.

### *3.1.3 Reforms in the Health Sector*

The Second National Health Sector Strategic Plan 2005-2010 (NHSSP II) gives priority to health financing through the National Social Health Insurance Fund (NSHIF), investments to benefit the poor, cross-sectoral cooperation, increased efficiency and effectiveness, and increased Government of Kenya (GoK) funding.

The main components of the Public Sector Reform agenda for MOH include the revision of the institutional framework, core functions and service delivery mechanisms, strategic partnerships, financial and human resource management, governance and building consumer confidence in the system and services. Underpinning these reforms is greater attention to regulation, delegation and decentralisation to give greater autonomy to districts and facilities, greater participation and ownership by communities (the latter defined in the new Community Health Strategy) and increased use of research to inform policy and strategy.

Reproductive health is an essential priority in the Kenya Essential Package for Health (KEPH) system (see section 4.1.1). The Health Sector Reform Programme (HSRP) recognizes the role played by other actors in financing and providing RH care and the need to promote collaborative efforts in line with the MoH plan and

standards, including the use of the same indicators for accurate assessment of progress against agreed targets as well as efficiency and effectiveness in service delivery. The sector-wide approach (SWAp) will provide a mechanism through which government stewardship of the health programme is facilitated.

Development partners will be encouraged to provide financing through this mechanism, thereby reducing transaction costs and encouraging transparency and efficiency.

### 3.1.4 Reproductive Health Challenges

The National Reproductive Health Strategy 1997-2010 was developed in response to the Programme of Action of ICPD of 1994. The goal of the strategy is to provide a comprehensive and integrated system of reproductive health care through government, civil society organisations, and the private sector facilities. However, implementation of the strategy has been affected by a number of challenges, including the impact of HIV/AIDS epidemic; a general shift of focus for international assistance from population to HIV/AIDS; disparities in health resource allocation; and lack of specific interventions targeting the resources to the poor and the 'hard to reach' populations. The result of inadequate funding has been a weak health system, inefficient integration and poor quality of service delivery, contributing to evident negative trends in RH-related input and outcome indicators as revealed in the Kenya Demographic and Health Survey (KDHS) of 2003. This reproductive health policy addresses these challenges and provides a framework for the revision of the National Reproductive Health Strategy, 1997-2010. The formulation of this policy was guided by relevant national policy and legal instruments and international conventions<sup>2</sup>.

2.

- GoK (2000). *National Population Policy for Sustainable Development*, Nairobi: Government Press.
- GoK (1994). *The Kenya Health Policy Framework*, Nairobi: Ministry of Health.
- GoK (1999). *National Health Sector Strategic Plan I 1999-2004*, Nairobi: Ministry of Health.
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- GoK (2003). *Economic Recovery Strategy for Employment and Wealth Creation 2003-2007*, Nairobi: Government Press.
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- GoK (2005). *Kenya National HIV/AIDS Strategic Plan 2005/6-2009/10*, Nairobi: Ministry of Planning and National Development and Ministry of Health.
- *International Conference on Population and Development (1994) and ICPD+10 (2005)*.
- *United Nations Fourth World Conference on Women (1995)*.
- *United Nations Millennium Development Goals (2001)*.
- *Reproductive Health: Draft Strategy to Accelerate Progress towards the Attainment of the International Development Goals and Targets* World Health Organisation/AFRO (2003).

## 3.2 RH Policy Goal

The goal of this policy is to enhance the reproductive health status of all Kenyans by:

- a) Increasing equitable access to reproductive health services;
- b) Improving quality, efficiency and effectiveness of service delivery at all levels; and
- c) Improving responsiveness to client needs.

### 3.2.1 Policy Objectives

The objectives of this policy are to:

- a) Reduce maternal, perinatal and neonatal morbidity and mortality;
- b) Reduce unmet family planning needs;
- c) Improve sexual and reproductive health of adolescents and youth;
- d) Promote gender equity and equality in matters of reproductive health, including access to appropriate services;
- e) Contribute to reduction of the HIV/AIDS burden and improvement of the RH status of infected and affected persons;
- f) Reduce the burden of reproductive tract infections (RTIs) and improve access to, and quality of, RTI services;
- g) Reduce the magnitude of infertility and increase access to efficient and effective investigative services for enhanced management of infertile individuals and couples;
- h) Reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women;
- i) Address RH-related needs of the elderly; and
- j) Address the special RH-related needs of people with disabilities.

### 3.2.2 Priority RH Components

Availability of resources will periodically require prioritisation in accordance with needs of the national RH programme. In this connection, the MoH has prioritised

the following four components of RH based on both magnitude and significance of the problem: safe motherhood; maternal and neonatal health; family planning; adolescent/youth sexual and reproductive health; and gender issues, including sexual and reproductive rights. Other priority components of RH addressed in this policy are: HIV/AIDS, reproductive tract infections, infertility, cancers of reproductive organs and RH for the elderly. There are inter-relationships among these components. For example, family planning plays a key role in the prevention of unintended pregnancies, which often lead to unsafe abortion, a major cause of maternal mortality. RTIs, particularly STIs, predispose both men and women to infertility. Infections related to female genital cutting (FGC) can also contribute to infertility, while scarring of the genitalia may cause difficulties in labour leading to increased risk of maternal and perinatal morbidity and mortality. All the above are key challenges of different components of reproductive health.

### **3.3 Reproductive Health Policy Components**

#### *3.3.1 Safe Motherhood, Maternal and Neonatal Health*

Maternal and neonatal morbidity and mortality levels in Kenya have remained unacceptably high. The maternal mortality ratio has remained at over 400 per 100,000 live births since 1998. The neonatal mortality rate was estimated at 33 per 1,000 live births in 2003 (28 per 1,000 live births in 1998), while the perinatal mortality rate was estimated at 40 in 2003 and 45 per 1,000 live births in 1998. Statistics from the 2003 KDHS indicated that nationally, only 42 per cent of births in Kenya were attended to by a skilled attendant, a figure that varied regionally and by economic status. Skilled attendance implies access to appropriately trained health providers whether in a health facility or through domiciliary care, and having access to a rapid means of referral in case of emergency. In this context, the traditional birth attendants (TBAs) are not recognised as providers of skilled care. Most neonatal deaths are due to infections, birth asphyxia, birth injuries,

complications of prematurity and low birth weight, and birth defects. In the case of maternal deaths, most result from one or more of five “direct” obstetric complications: postpartum haemorrhage, obstructed labour/ruptured uterus, pre-eclampsia/eclampsia, puerperal sepsis, and unsafe abortion. Among the “indirect” causes of maternal deaths are: severe anaemia, malaria, HIV/AIDS and tuberculosis.

All pregnant women need to have access to skilled care<sup>3</sup> throughout pregnancy, delivery, postpartum and postnatal periods<sup>4</sup>. Further, with so little change in the proportion of women choosing to deliver in health facilities even when these are accessible, the health system needs to improve its responsiveness to client needs.

The following are key challenges to safe motherhood, maternal and neonatal health:

- a) Inadequate access by women to RH information and to skilled care throughout the continuum of pregnancy, delivery, post-partum and post-natal periods, especially the rural and urban poor, and women living in arid and semi-arid regions, pastoral and nomadic populations and other hard to reach groups;
- b) Weaknesses in the health system, including service provision and referral that negatively affect access to, quality of care, demand for and utilisation of reproductive health services;
- c) Redefining the role of other community-owned resource persons (CORPs) including TBAs with regard to pregnancy, early identification and referrals of complications, post-natal care and registration of births; and
- d) Inadequate access to improved care of the newborn, including facilities for resuscitation, thermal regulation, infection prevention and promotion of early and exclusive breastfeeding.

3. • *A skilled attendant as defined by the World Health Organisation (WHO) is “a health professional – such as a midwife, doctor, [clinical officer –ed.] or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (World Health Organisation, 2004)*

4. • *In at least 15 per cent of pregnant women serious obstetric complication can occur that usually cannot be predicted or prevented in advance.*

## Priority Actions

To reduce maternal, perinatal and neonatal morbidity and mortality in Kenya, the safe motherhood component of the reproductive health programme will:

- a) Ensure that all women, including adolescents/youth have access to reproductive health information, counselling and services;
- b) Ensure that all pregnant women, including the poor and 'hard-to-reach', have access to skilled care throughout pregnancy, delivery, postpartum, postnatal periods and care of the newborn; and that TBAs are not recognised as providers of skilled care;
- c) Increase access to both comprehensive and basic emergency obstetric care to meet minimum international standards;
- d) Remove barriers (geographic, socio-cultural, economic, legal or regulatory) that impede access to skilled care for the poor and 'hard-to-reach' women, including promotion of community midwifery services, women- and baby-friendly services, and establishment of maternity shelters, as appropriate;
- e) Ensure that communities are involved in measures to promote 'women-and baby-friendly' maternity services and assisting with transport;
- f) Ensure that referral networks across public and non-public facilities are promoted and strengthened;
- g) Strengthen the capacity of the health system at all levels for efficient and effective delivery of services for the newborn, including resuscitation, thermal regulation, infection prevention and promotion of early and exclusive breastfeeding;
- h) Strengthen the capacity of CORPs, including TBAs to enable them play designated roles such as promotion of birth-preparedness, early identification and referrals of complications, post-natal care and registration of births; and

- i) Review all maternal and perinatal deaths and provide notification on maternal deaths.

### 3.3.2 Family Planning

The Family Planning Programme, started in 1967 by the Ministry of Health, has contributed considerably to the decline in fertility rates in Kenya. The TFR estimated at 8.1 in 1977/78 declined to 4.7 in 1998, but increased to 4.9 in 2003. The contraceptive prevalence rates (CPR) for all methods and modern methods were estimated in 2003 at 39 per cent and 32 per cent, respectively. Although the 2003 CPR estimate for modern methods indicates a two-fold increase since 1989, the 1998-2003 trend data reflect stagnation at 32 per cent. The Kenya Service Provision Assessment (KSPA) survey indicates that only 73 per cent of all health facilities are offering temporary methods of family planning services.

Unmet need for family planning among married women in Kenya has remained high, at about 24 per cent since 1998. On the other hand, the population projections show that the number of couples of reproductive age together with sexually active unmarried individuals in need of family planning information and services will grow by about 200,000 per annum in the 2005-2015 period<sup>5</sup>.

The following are the key challenges:

- a) Wide regional and socio-economic disparities in CPR;
- b) Lack of security for contraceptive commodities;
- c) Lack of sustained demand creation for family planning services;
- d) Relatively low community and private sector participation in family planning service provision and low involvement of males;
- e) Method mix that does not permit wide method choice and cost-effectiveness;
- f) Inadequate family planning training for service providers; and
- g) Low level of integration of family planning with HIV/AIDS services.

5. • CBS (2002). *Analytical Report on Population Projections, Volume VII, Nairobi: Government Press*



## Priority Actions

To reduce the unmet need for family planning, unplanned births as well as regional and socio-economic disparities in CPR, the family planning component of the reproductive health programme will:

- a) Create sustained demand for family planning services;
- b) Guarantee contraceptive commodity security;
- c) Promote increased involvement of men in family planning, including increased use of male methods for improved family planning services uptake;
- d) Promote participation of communities, including CORPS and the private sector, in provision and financing of services at all levels;
- e) Ensure strengthened reproductive health service delivery systems at all levels to improve efficiency, quality and integration of family planning and HIV/AIDS services; and
- f) Promote social marketing of contraceptives to increase access through non-formal channels.

### 3.3.3 Adolescents/Youth Sexual and Reproductive Health

In Kenya, the Children Act of 2001 defines any person under 18 years of age as a child. Adolescents and youth (generally defined as persons 10-19 and 10-24 years, respectively) make up 36 per cent of the population. While adolescent fertility has remained high despite declines experienced among other age groups, this group is also most at risk of unplanned pregnancy, unsafe abortion, STIs, and HIV and AIDS. Girls aged 15-19 years are twice as likely to die of pregnancy-related causes as women aged 20-24 years.

The Adolescent Reproductive Health and Development (ARH&D) Policy of 2003 recognises that the optimal health of the adolescent population of Kenya will

increase their productive capacity to contribute to the nation's development. Specific problems experienced by adolescents and youth, as outlined in the policy, include unprotected sexual activity, malnutrition, menstrual problems, school drop-out, harmful practices (female genital cutting, early forced marriage, sexual violence and abuse) and mental health problems.

The ARH&D Policy addresses the following priority strategic concerns: adolescent sexual and reproductive health and rights; harmful practices; drug and substance abuse; socio-economic factors; and adolescents and youth with disabilities. In addition to the ARH&D priorities, this policy focuses on enhancement of adolescent sexual and reproductive health and reduction of impacts of harmful practices, sexual abuse and violence.

The following are the key barriers to improved sexual and reproductive well-being and quality of life of Kenya's young people:

- a) Inadequate access by adolescents and youth to reproductive health information and youth-friendly services; and
- b) Inadequate focus of reproductive health programmes to adolescent and youth with varied needs.

### **Priority Actions**

To improve the sexual and reproductive health of Kenya's adolescents and youth, the reproductive health programme will:

- a) Ensure that adolescents and youth have full access to sexual and reproductive health information and services;
- b) Establish high-quality, comprehensive and integrated youth-friendly reproductive health services that also address the diverse needs of adolescents and youth, including those infected or affected by HIV, youth with disabilities and the hard to reach;

- c) Promote a multi-sectoral approach in addressing adolescent sexual and reproductive health needs; and
- d) Strengthen partnerships and referral with NGOs and FBOs working with youth, with emphasis on those who are hard to reach.

### *3.3.4 Gender Issues, Sexual and Reproductive Rights*

Unequal social relations between men and women produce inequalities in health outcomes and access to, and use of reproductive health information and services. Gender issues and sexual and reproductive rights are closely interrelated and jointly affect the productive and reproductive health of both men and women. Although reproductive rights are part of human rights and are recognised in Kenyan laws, men still exercise predominant power in nearly every sphere of life including personal decisions regarding the size of families and women's own reproductive health. The 2003 KDHS data show that only half of all women participate alone or jointly in decision-making in their own health care.

Harmful cultural practices including nutritional taboos violate the reproductive rights and impede attainment of healthy and fulfilling reproductive lives, especially among women. In Kenya, harmful practices of major concern to reproductive health are early or child marriages, FGC and nutritional taboos that affect the health of girls and women. The 2003 KDHS reported that about 5 per cent of women aged 20-49 years were first married by age 15 years. The report also estimated FGC prevalence at about 32 per cent suggesting only a slight decline from the 38 per cent recorded in 1998. FGC contravenes several basic rights of women and girls, including the right to liberty and security of person, and the right to be free from inhumane and degrading treatment. In addition, some of these practices contravene the provision of the Children's Act of 2001 and the Sexual Offences Act of 2006.

The forms of gender-based violence of great concern to reproductive health are physical and sexual abuse and violence, including rape. These are violations of the right to be free from inhumane and degrading treatment, besides having severe psychological, emotional and medical consequences, including increased risk of unintended pregnancy and sexually transmitted infections, such as HIV/AIDS. Currently, there is poor reporting of gender-based violence, which is compounded by limited access to services by the victims. The 2003 KDHS provides the first national data on sexual, physical and other forms of violence. About 43 per cent of women aged 15-49 years reported to have experienced some form of gender-based violence in their lifetime, with 29 per cent reported having been violated in the year preceding the survey. The prevalence rate of sexual abuse was estimated at 13 per cent among females aged 15-49 years.

The following are the key challenges:

- a) Low participation of women in decision-making regarding their own reproductive health;
- b) Low involvement of males in reproductive health programmes; and
- c) Poor coverage and limited access to reproductive health treatment and rehabilitative services for individuals whose rights have been violated.

### **Priority Actions**

To promote gender equity and equality in decision-making in matters of reproductive health and to contribute to the elimination of harmful practices within a multi-sectoral and legal framework, the reproductive health programme will:

- a) Ensure access to quality treatment and rehabilitative reproductive health services for those affected by harmful practices and gender-based violence, including an effective referral system among health facilities, police and legal services;
- b) Promote male involvement in the reproductive health programme,

- including provision of male-friendly services;
- c) Promote empowerment of women in reproductive health decision-making; and
- d) Promote participation of households and communities in addressing harmful practices and gender inequity in reproductive health.

### 3.3.5 *HIV and AIDS*

The HIV and AIDS epidemic continues to pose a serious threat to all sectors of the Kenyan economy. In 2004, an estimated 1.1 million adults aged 15-49 years, 60,000 adults aged 50 years and above, and approximately 100,000 children in Kenya were living with HIV or AIDS. It is estimated that 1.5 million Kenyans have died of AIDS. Although there has not been a comprehensive assessment of OVC, it was estimated that there were 1.9 million orphans in 2005, and the number is projected to reach 2.1 million by 2010.

A multi-sectoral response to the epidemic is being implemented, and the overall prevalence rate has begun to fall, though there is wide regional variation. Meanwhile, voluntary counselling and testing (VCT) services have increased significantly, resulting in a growing proportion of Kenyans being aware of their HIV status, as the scale-up of anti-retroviral therapy (ARVT) continues. However, the rate of new infection remains unacceptably high, there being major variations in vulnerability to infection. Infection rates continue to be higher in women compared with men. For example, the 2003 KDHS reported the overall HIV prevalence rate as 6.7 per cent, but was 8.7 per cent in women and 4.6 per cent in men.

Mother-to-child transmission is the second main mode of HIV transmission, taking place during pregnancy, labour and delivery or during the breastfeeding period. The National Guidelines for Prevention of Mother-to-Child HIV/AIDS Transmission of 2000 encourages all pregnant women to know their HIV status

as well as that of their partners. It also recommends HIV counselling and testing as part of a comprehensive antenatal package of care. Thus, increasing access to essential obstetric care and family planning services are key strategies towards prevention of this mode of HIV transmission, and for addressing the unmet need for contraception among people living with HIV or AIDS (PLWHA). The unmet need for contraception among PLWHA is in part related to stigma, negative provider attitudes, as well as inadequate knowledge among service providers regarding contraceptive use by HIV-infected persons.

Increased availability of anti-retroviral therapy is expected to increase the population of HIV-infected persons in need of reproductive health services. Reproductive health services are important entry points for most HIV/AIDS services, especially prevention of mother-to-child transmission (PMTCT), VCT and ARVT interventions. However, the integration of HIV/AIDS services into RH services remains inadequate.

The following are key challenges:

- a) Unmet need for reproductive health services among HIV-infected persons - addressing stigma, negative attitudes of service providers, and knowledge gaps regarding interactions of anti-retrovirals (ARVs) and contraceptive methods;
- b) Knowledge gaps regarding interaction of ARVs and contraceptive methods; and
- c) Inadequate integration of reproductive health and HIV/AIDS services, despite both programmes providing good mutual entry points for addressing unmet need for particular reproductive health or HIV/AIDS services, including prevention of new HIV infections.

### **Priority Actions**

To contribute to the reduction of HIV/AIDS burden and improvement of

reproductive health status of the infected and affected, the reproductive health programme will:

- a) Ensure integration of HIV/AIDS information and services into RH services at all levels of health care, including integration of HIV counselling and testing as part of a comprehensive antenatal package of care; and
- b) Ensure adequate capacity at all levels for the provision of integrated, high-quality RH services in the context of HIV/AIDS.

### *3.3.6 Reproductive Tract Infections*

RTIs have serious impacts on health, and are contributors to infertility, maternal and perinatal morbidity and mortality. Although there is lack of a routine and regular surveillance and reporting system, data from several limited studies suggest that RTI incidence in Kenya is high. Most available data are in respect to bacterial STIs and HIV/AIDS. There is scarcity of data on endogenous infections, especially bacterial vaginosis, and viral infections such as herpes simplex virus (HSV2) and human papilloma virus (HPV) and their social and reproductive health implications among women. In women, RTIs are often asymptomatic, making it more difficult to diagnose than in men, and as a result treatment is frequently delayed, increasing the risk of ascending pelvic infection and infertility. Classical STIs may amplify the transmission of HIV, for example genital ulcer disease, while HIV/AIDS may prolong the duration of symptoms, thereby influencing transmission of STIs. Thus, effective treatment of RTIs is an important prevention strategy for both HIV and complications of RTIs. Antenatal screening and treatment for syphilis is a long-established strategy for the prevention of maternal-fetal transmission of syphilis and its impacts.

The following are key challenges:

- a) Inadequate integration of RTIs treatment into reproductive health services;

- b) Inadequate access to, and poor quality of RTI services;
- c) Low levels of community awareness of RTIs; and
- d) Scarcity of data on RTIs.

### **Priority Actions**

To reduce the burden of RTIs and improve access to high-quality RTI services within reproductive health activities, the reproductive health programme will:

- a) Enhance community awareness of the impacts of RTIs, including non-sexually transmitted endogenous RTIs, on the reproductive health of women and men;
- b) Ensure integrated, high-quality RTI services at all levels, including strengthened capacity for screening services;
- c) Encourage generation of information and research on RTIs;
- d) Ensure that STI prevention and control approaches contribute to HIV prevention; and
- e) Ensure adoption of proven new modalities of prevention and treatment of reproductive tract infections when available, especially for viral infections.

### **3.3.7 Infertility**

Infertility is an important public health concern in Kenya. However, the problem has been inadequately addressed at both policy and service levels, mainly due to its ranking against other perceived pressing priorities of maternal and child health care. Prevalence of infertility in Kenya remains inadequately determined, but depending on the definition applied it may range from as low as 2 per cent to over 20 per cent. The 2003 KDHS reported that 2.2 per cent of women aged 40-49 years had not given birth to a child, which may imply primary infertility. However, secondary infertility may exist in a much larger proportion of women depending on the desired family size norms and the extent of pregnancy wastage.



Infertility has strong gender implications. Regardless of the medical cause of infertility, women bear the major brunt of blame and social ostracism. Considering that RTIs are the leading contributors to infertility in both men and women, their prevention and effective treatment are key management strategies (see section 3.3.6).

The following are key challenges:

- a) Limited access to infertility services;
- b) Delay in seeking health care by affected individuals and couples; and
- c) Knowledge and attitudes towards infertility.

### **Priority Actions**

To reduce the magnitude of infertility and increase access to proper investigation and management of infertile individuals and couples, the reproductive health programme will:

- a) Improve access to quality infertility services at all levels;
- b) Promote community awareness on infertility, especially among males; and
- c) Encourage research on all aspects of infertility.

### **3.3.8 Cancers of Reproductive Organs**

Cancers of the reproductive organs are important causes of morbidity and mortality among women and men. Cancers of the cervix and breast are the leading malignant diseases among women, while cancers of the prostate and testes are common in men. Both cervical and breast cancers present opportunities for their early detection since both develop in organs that are easily accessible by inspection or palpation. Similarly, prostate and testicular cancers can be detected early by careful clinical examination aided by biochemical markers. Early detection and effective treatment of pre-malignant lesions are important for reduction of mortality and morbidity associated with these cancers.

The following are key challenges:

- a) Inadequate access to comprehensive reproductive organ cancer prevention, early detection, and management services;
- b) Delay in seeking health care; and
- c) Limited information among communities on cancers of reproductive organs.

### **Priority Actions**

To reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women, the reproductive health programme will:

- a) Increase availability of high-quality services for the prevention, early detection and management of cancers of reproductive organs, as appropriate at all levels;
- b) Enhance programmes that advocate for, create awareness of, and sensitise the community on cancers of reproductive organ; and
- c) Promote research on all aspects of cancers of the reproductive organs.

### **3.3.9 Reproductive Health for Elderly Persons**

The demographic transition towards lower fertility levels is expected to increase the proportion and number of elderly persons. Persons aged 65 years and above formed about 4 per cent of the Kenyan population in 1999 while the number aged 50 years and above is projected to reach 3.7 million by the year 2015<sup>6</sup>. The elderly are highly vulnerable to poverty, and consequently have limited access to health care including RH services. Elderly people, particularly older women, are sometimes victims of gender-based violence and discrimination. Health problems among elderly persons relate mainly to the higher incidence of chronic illnesses, including cancer and degenerative diseases, as well as complications of menopause in women and andropause in men. Many health problems of women of post child-bearing age are directly related to their

6. • CBS (1999). *Population and Housing Census – Analytical Report on Population Projections, Volume VII, Nairobi: Government Press.*

early life-styles and habits, as well as their reproductive experiences. These may be minimised through integration of preventive measures in RH programmes. Current RH services lack a focus on problems of the elderly.

The following are key challenges:

- a) Inadequate reproductive health programmes targeting elderly persons;
- b) Lack of a comprehensive and integrated RH services for elderly persons;
- c) Lack of data on RH indicators among the elderly.

### **Priority Actions**

To address RH-related needs of the elderly persons, the reproductive health programme will:

- a) Promote/improve access to quality and comprehensive sexual and reproductive health services at all levels by elderly people; and
- b) Advocate and create awareness in the community for the elimination of all forms of violence and discrimination against elderly people.

## 4. IMPLEMENTATION FRAMEWORK

### 4.1 Provision of Reproductive Health Services

Priority reproductive health needs and related intervention measures will be implemented in line with the Second National Health Sector Strategic Plan, 2005-2010 (NHSSP II) and the ERSWEC through a multi-sectoral approach including collaboration with civil society and the private sector. The goal is to reduce inequalities in health resource allocation and improve access to RH services by poor, 'hard to reach' and vulnerable groups. All health care facilities, from the community level to national level institutions, have a role to play in the provision of sexual and reproductive health services. The NHSSP II intends to reverse the decline in the health status of Kenyans through an efficient, high-quality health care system that is accessible, equitable and affordable by every household. The NHSSP II has laid down supportive measures ranging from community involvement, human resources and financial management, infrastructure, and institutional reforms to monitoring and evaluation. The DRH in its stewardship role of reproductive health, will steer the revision of Reproductive Health Strategy, 1997-2010 in line with the Kenya Essential Package for Health (KEPH) as well as the framework for service provision defined in the Norms and Standards for Health Service Delivery of April 2006.

#### 4.1.1 Kenya Essential Package for Health

To achieve its goal, NHSSP II has formulated a common service delivery package, the KEPH, focusing health service delivery at the following segments of the human life cycle:

- a) Pregnancy, delivery and the newborn child (up to two weeks of age)
- b) Early childhood (3 weeks to 5 years)
- c) Late childhood (6 to 12 years)
- d) Adolescence and youth (10 to 24 years)
- e) Adulthood (25 to 59 years)
- f) Elderly (65 years and over)

The MoH's key strategy for health service delivery is decentralisation of services to the districts, including implementation of the essential package of services. The health package in the KEPH has been classified into high, medium and low priority. Reproductive health is in the high priority category.

Service delivery is provided at the following six levels:

- a) KEPH Level I – Community level
- b) KEPH Level II – Dispensary
- c) KEPH Level III – Health Centre, Maternity Homes, Nursing Homes
- d) KEPH Level IV – Primary Hospital
- e) KEPH Level V – Secondary Hospital
- f) KEPH Level VI – Tertiary Hospital

Facilities operated by NGOs, FBOs and the private for-profit sector will follow the same classification depending on their level of resources and capacity. In addition, data from these facilities will be included in the MoH M&E system. Ensuring a well-functioning referral system is critical to making it possible for clients at all levels to gain access to appropriate skilled care.

#### *4.1.2 The RH Service Delivery Framework, Norms and Standards*

Kenya's health sector comprises a network of public and private dispensaries, health centres, maternity and nursing homes, and hospitals at the district, provincial and national levels. In order to ensure high-quality service delivery, the KEPH requires an appropriate mix of inputs, which include human resources, infrastructure and commodities. The delivery of reproductive health services will be under the framework defined in the Norms and Standards for Health Service Delivery of April 2006. These standards define expectations for care at each level and the resource inputs that are needed to efficiently, effectively and sustainably offer the specified service package. These include:

- a) The health system structure needed to deliver the defined health services

- in an efficient, equitable and sustainable manner;
- b) The expected service standards for different activities, to ensure comprehensive health service delivery;
  - c) The minimum human resources and infrastructure needed to ensure that the different levels of the system are able to offer the expected service standards; and
  - d) The supervision and monitoring for adherence to the norms and standards.

## 4.2 Reproductive Health Systems

The strength of a health system is a key determinant of the quality of services it offers. An efficient, effective and sustainable reproductive health system will be developed focusing on the following service provision components: human resources, financial resources and other support systems.

### a) Human Resources

The human resource for reproductive health care provision will be enhanced by:

- i) Building capacity after reviewing staff norms, deployment and retention of service providers at all levels;
- ii) Training and supervising service providers at all levels using standardized procedures;
- iii) Transferring clinical skills through use of other modern methods of training, including on-job-training and certification processes; and
- iv) Deploying service providers skilled in sexual and reproductive health care at all levels in line with the Health Sector Strategic Plan.

## **b) Financial Resources**

It is necessary to increase financial resources for reproductive health services, and to increase efficiency in financial management, by carrying out the following actions:

- i) Seek increased government budgetary allocation for reproductive health services, especially for KEPH levels I to IV, where health resources have been shown to be most effective in reducing the burden of disease and in improving people's health;
- ii) Coordinate and harmonize donor support to ensure that both pool and discrete resources are predictable and planned for;
- iii) Establish a mechanism to promote close working relationships among stakeholders, including government ministries, CSOs, FBOs, private and corporate sectors;
- iv) Establish mechanisms for tapping financial resources, especially from non-public sectors; and
- v) Improve efficiency in resource utilisation, including integrating services and promoting more cost-effective and efficient contraceptive technologies.

## **c) Other Support Systems**

Support systems for the reproductive health programme will be improved by carrying out the following activities:

- i) Strengthen the reproductive health information systems;
- ii) Build and/or expand infrastructural facilities, including transport and communication for reproductive health service delivery;
- iii) Enhance efficiency of the procurement system and commodity supply chain for reproductive health service provision; and
- iv) Develop/review reproductive health service guidelines and standards and their dissemination at all levels.

## 4.3 Management and Coordination

### 4.3.1 Management and Coordination Framework

This reproductive health policy will be implemented in accordance with the overall health sector management and coordination framework, contained in the NHSSP II. It will be managed and coordinated by the DRH at the national level and by the Provincial and District Management Teams and Boards at provincial and district levels, and the Village and Health Facility Committees at the community and facility levels.

### 4.3.2 Roles and Responsibilities

#### 4.3.2.1 Role of the Ministry of Health (MoH)

The Ministry of Health will oversee and facilitate implementation of this reproductive health policy and ensure that there is adequate capacity in terms of staffing, equipment and supplies. The MoH through the DRH will develop an integrated strategic plan, set standards and regulatory mechanisms, regulate and co-ordinate reproductive health training, co-ordinate donor activities, and ensure adequate allocation of resources to the reproductive health programme. The Joint Inter-agency Coordinating Committee (JIACC) will be the key mechanism for involving other ministries and development partners in coordinating resource mobilisation and allocation, while the Reproductive Health Inter-agency Coordinating Committee (RH-ICC) will be the mechanism for involving stakeholders to develop the RH strategic plan, standardise and review implementation protocols, guidelines and procedures. The MoH will ensure collaboration among departments and divisions within the ministry and other ministries as identified in Section 4.3.2.2.

Decentralisation will be promoted, as it is critical to the successful delivery of health care services countrywide. At provincial and district levels, the



Provincial Health Management Teams (PHMTs) and District Health Management Teams (DHMTs) will supervise the planning and implementation of all reproductive health programme activities, including enforcement of reproductive health standards, setting priorities, and collaboration with development partners, FBOs, CSOs and other partners in RH and related activities in their respective areas of jurisdiction. The District Health Management Boards will play an oversight role on reproductive health matters, including resource mobilisation, ensuring quality of services, and monitoring and evaluation.

The reproductive health training and supervision (RHT&S) system will be strengthened to enable it to provide effective services to the provinces and districts. In addition, provincial and district health stakeholder fora will be held regularly to review proposals and health plans formulated by the PHMTs and DHMTs. Further, the MoH will support the establishment of Village and Health Facility Committees as a management and coordination mechanism at KEPH levels I to III.

#### 4.3.2.2 Roles of Other Ministries

A multi-sectoral approach will be promoted during the implementation of this policy. The following are some key sectoral ministries that will be involved:

Ministry	Role(s)
Ministry of Planning and National Development	Policy advocacy, resource mobilization, data/information
Ministry of Education	Implementation of ARH&D policy and research
Ministry of Information and Communication	IEC of RH messages, communication infrastructure
Ministry of Finance	Financial resource allocation
Ministry of Gender	Support the gender component of the RH programme
Office of the President	Support advocacy initiatives for RH
Ministry of Home Affairs	RH issues for vulnerable groups
Ministry of Roads	Road networks
Ministry of Agriculture	Food security
Ministry of Water	Community and facility water supply

*The Ministry of Health will encourage these ministries to mainstream reproductive health issues in their core functions.*

*NB: IEC stands for information, education and communication*

#### *4.3.2.3 Roles of NGOs, CBOs, FBOs and Private Sector*

The Government acknowledges the significant roles played by non-public sector organisations in the provision of RH services, and will continue, through MoH, to provide an enabling environment for the enhancement of private/public sector partnerships. The MoH will encourage non-public sector organisations to expand coverage and improve access to RH care as well as participate in the formulation, financing, implementation, monitoring and evaluation of reproductive health programmes.

#### *4.3.2.4 Role of Development Partners*

Development partners will be encouraged to support the provision of reproductive health care through SWAp and shared arrangements, where appropriate and in accordance with the national RH priorities and plans.

#### *4.3.2.5 Role of Communities, Households and Individuals*

Communities will participate through the Health Facility Committees (HFC) and Village Health Committees (VHC) as well as through CORPs, in resource mobilisation, planning, and monitoring and evaluation of RH services. Households and individuals will be encouraged to participate and contribute towards improvement of their own RH status.

#### *4.3.2.6 Role of Training Institutions*

The approved university-based medical and nursing schools, the Kenya Medical Training Colleges (KMTTC) and the private and mission medical training hospitals are expected to conform to the standardised national RH curriculum in addition to other international standards that contribute to delivery of high-quality RH care.

#### *4.3.2.7 Role of Mass Media*

The mass media will be expected to play a key role in advocacy and creation of

public awareness on matters related to reproductive health in line with existing reproductive health communication strategy.

#### *4.3.2.8 Roles of Other Stakeholders*

Other stakeholders are expected to facilitate greater public participation and involvement in planning and implementation of reproductive health programmes. These other stakeholders include women's organisations, professional associations, regulatory bodies and political parties.

## **4.4 Reproductive Health Research**

Research is a powerful tool for providing evidence-based information for policy formulation and review, and for development of guidelines and standards. The MoH will encourage other stakeholders to promote research and exchange of information between researchers and the end-users of research results, at different stages in the research process. Research institutions and other organisations that participate in research are expected to address research priorities, standards, protocols and ethics as indicated in the RH Research Agenda and the National RH Research Guidelines of the Ministry of Health.

## **4.5 Monitoring and Evaluation**

Monitoring and evaluation of this reproductive health policy will use the M&E framework of the National Health Strategic Plan to track progress in programme implementation and service delivery. The DRH will ensure that the tools used in data gathering are designed to capture relevant data. Human and other necessary capacities will be strengthened to facilitate timely processing and analysis of the data collected.

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